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THE Ohio STATE
Medical Journal
Vol. 77, No. 1, January 1981

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The road ahead

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Second in the Third-Party Payers Series

1981 Journal Photographic Exhibit Contest
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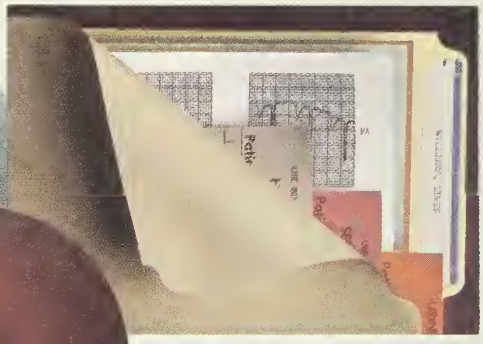
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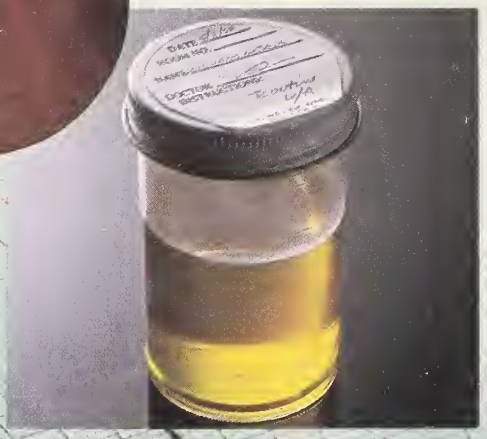
HYPERTENSION MAY BE YOUR DIAGNOSIS OF HIS PHYSICAL CONDITION

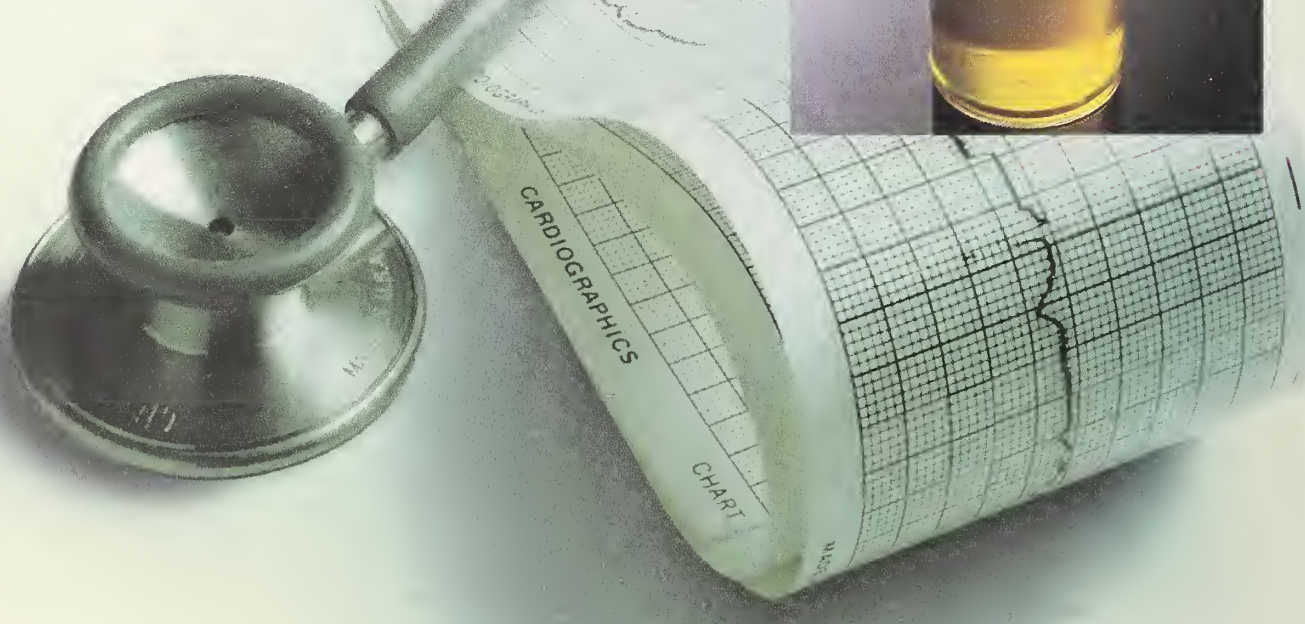
On three different visits, the patient's readings have hovered about the 150/95 mmHg level. Both his father and uncle are currently being treated for high blood pressure; a paternal grandfather died in his 60's of a stroke. Neither the physical examination nor the laboratory workup indicates target organ damage or coexisting disease. Cholesterol levels (250 mg/dL) are on the high side, however.

The patient is 30 pounds overweight, smokes several cigars a day, and has a sedentary office job. He admits he likes his food highly spiced—and over-salted. Besides considering appropriate antihypertensive agents, you may also wish to design a treatment program that includes weight control, salt restriction and exercise.

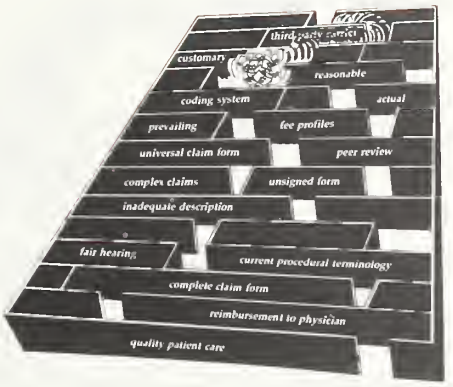








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The OSMA Legislative staff
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Our Cover

"Storm Clouds Over the Pacific: Kona Coast, Kauai, Hawaii" earned its photographer, George Waylonis, M.D., Columbus, an "outstanding" entry in last year's *Journal* Photographic contest. The view was snapped with a Nikomat camera, using pantomic X film, which was developed and printed by Dr. Waylonis. For details on entering this year's Photographic Contest, see page 19.



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Letters ...to the editor

To the Editor:

I've just finished reading the October issue of the *Journal*, and wanted to let you know that I think it has become a super publication. The *Journal's* new look is very attractive, and the articles are informative and well written. The *Journal* has come a long way in recent years, and I look forward to seeing it each month.

Sincerely,
/s/**Jan Tanner**
Assistant Manager, Public Affairs
Burroughs Wellcome Company

Editor's Note: Ms. Tanner served as *Journal* editor from October 1974 to November 1975, and can be credited with beginning a line of continuous changes which have resulted in the *Journal's* present form.

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—from *The Art of Poetry* (1674) by Nicholas Boileau-Desprēaux

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COLLEAGUES IN THE NEWS

VIRENDRA K. BHACHAWAT, M.D., Canton, was named a Fellow of the American Academy of Family Physicians.

DUDLEY F. BRIGGS, M.D., Columbus, was elected to a second term as president of the Mental Health Association of Ohio. Dr. Briggs is Medical Director of Western Electric Company.

JOHN DODD CAMERON, M.D., Defiance, was honored by the Ohio State Medical Association for 50 years of distinguished service to medicine. The award was presented by Hart F. Page, Executive Director of the Ohio State Medical Association.

CHARLES D. COBAU, M.D., Toledo, was elected president of the Ohio Valley-Lake Erie Association of Cancer Centers. Dr. Cobau is Director of the Toledo Clinic.

WERNER E. DONATH, M.D., Cincinnati, was reappointed to the Cincinnati Technical College Board of Trustees. Dr. Donath is chief pathologist at St. Francis-St. George Hospital.

MARK FEINGOLD, M.D., Cleveland, was named physician-in-charge of the new Kaiser-Permanente Medical Group. Dr. Feingold is director of emergency services at Kaiser Foundation Hospital and practices pediatrics at the Kaiser-Permanente Severance Medical Center.

HARVEY C. KNOWLES, M.D., Cincinnati, is this year's recipient of the Joslin Medal, given by the Northeast Affiliate of the American Diabetes Association, for his outstanding accomplishments in the field. Dr. Knowles is professor of medicine and director of the Division of Metabolism/Endocrinology in the Department of Internal Medicine, University of Cincinnati Medical Center.

STEVEN D. GROSSMAN, M.D., Youngstown, was named a diplomate of the American Board of Family Practice.

STANLEY POST, M.D., Cleveland, was reelected chief of staff for Booth Memorial Hospital. Other officers include: Edward Cerutti, M.D., Cleveland, assistant chief of staff, and Hurikadale P. Sundaresh, M.D., secretary-treasurer.

H. WILLIAM PORTERFIELD, M.D., was elected president-elect of the American Society of Plastic and Reconstructive Surgeons. Dr. Porterfield is a plastic surgeon practicing in Columbus, Ohio.

J. W. SCHOOLNIC, M.D., East Liverpool, was presented an award, "In recognition of 15 years of excellence in the organization of the annual Joan Smith Heart Lecture."

CHARLES G. YOUNG, M.D., Mansfield, was elected president of the Ohio Society of Internal Medicine. Other officers include: William J. Marshall, M.D., Dayton, president-elect; Lee McHenry, M.D., Cincinnati, vice president; and John F. Condon, M.D., Columbus, secretary-treasurer.

Third Party Problems?



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STATE & FEDERAL LEGISLATIVE UPDATE

Beginning with the next issue, the Department of State and Federal Legislation will provide background on current public health issues in the "Legislative Update" while the "Legislative Bulletin" will provide the latest reports on pending legislation affecting organized medicine.

LEGISLATIVE REVIEW

1980 was a very good year for organized medicine in Ohio. The OSMA legislative effort scored victory after victory through the combined efforts of the Association staff, the members, and the Auxiliary. This hard work was rewarded by the enactment of a number of proposals the OSMA supported and by the failure of every bill the OSMA opposed. The following is a selected summary of proposed legislation that was stopped through those efforts.

Optometric Drug Bill. House Bill 158 (Orlett, D-Dayton) would have allowed optometrists to use "diagnostic drugs." This bill was withdrawn by its sponsors after six years of legislative effort.

Physician Assistants. House Bill 16 (J. Thompson, D-Cleveland) would have permitted physician assistants to be employed by institutions and could have reduced the direct supervision of PA's now required by statute.

Physical Therapists. Had House Bills 210/211 (L. Brown, D-Columbus) become law, physical therapists might have tried to prohibit hospitals from providing physical therapy and could have required acceptance of physical therapists who applied for hospital privileges.

Nurse Practice Act Revision. House Bill 1029 (Orlett, D-Dayton) would have permitted nurses to practice independently and the proposed changes would have allowed the Nursing Board to redefine nursing practices, potentially permitting nurses to practice certain aspects of medicine.

Medicare Discrimination. Senate Bill 359 Butts, D-Cleveland) would have required physicians to see Medicare patients and would have prohibited them from asking the patient the source of payment for the physician's fee.

Chiropractic Acupuncture. House Bill 162 (Tranter, D-Cincinnati) would have permitted chiropractors, acupuncturists, and even veterinarians to perform acupuncture without physician supervision.

Third-Party Payer Immunity. Senate Bill 44 (Butts, D-Cleveland) would have prohibited physicians from suing third-party payers for libel, slander, or breach of contract when the company was engaged in a "cost control investigation." This bill would have given the payers "carte blanche" to attack a physician without fear of legal redress.

Hospital Service Association (HSA) Law Changes. House Bill 700 (Eckart-D, Euclid) and Senate Bill 231 (Valiquette, D-Toledo) were statutory extensions of the previously enacted HB 448, requiring third-party payers to exercise "good faith efforts" through "incentives and disincentives" to "eliminate services and inappropriate utilization." HB 700 was never assigned to committee, and SB 231 never left the Senate Elections and Financial Institutions Committee.

Hospital Licensure. House Bill 753 (J. Thompson, D-Cleveland) was supported by the OSMA because of OSMA language restricting hospital admission authority solely to physicians. However, the bill would have increased the power of the JCAH by establishing the JCAH standards as the minimum requirement for a hospital license.

Determination of Death. House Bill 1085 (Gilmore, R-Columbus), the proposed "definition of death" bill, did not include an adequate concept of brain death. The OSMA will introduce its proposal for a determination of brain death in the new legislative session pursuant to Resolution 12-80.

Physician Office Inclusion in CON. Senate Bill 311 (Mahoney, D-Springfield) would have included the placement of physician offices under Ohio's Certificate of Need law. The OSMA successfully opposed inclusion of physician offices in the original bill and also defeated this attempt.

State Medical Board Revisions. Senate Bill 368 (Roberto, D-Ravenna) would have strengthened the statutory powers of the Medical Board. The OSMA supported the bill after resolving several problems in the original draft. Because of attempts by the Medical Board and others to shift the focus of the legislation, the bill failed in the last days of session. A more limited proposal may be introduced in 1981.

The OSMA also assisted in the enactment of several proposals into law. Other bills were listed in last month's update.

Stabilization Reserve Fund. Senate Bill 271 (Mahoney, D-Springfield) was the most impressive legislative accomplishment of the OSMA this year. The law mandated the return of $24.6 million to over 13,000 physicians and 200 hospitals in Ohio. The OSMA drafted the amendment that mandated the return, convinced the bill's sponsor to accept it, and lobbied it into law; then assisted the SRF in the return of the funds.

Privacy Law and Medical Records. Senate Bill 62 (Valiquette, D-Toledo) amended the state privacy law to exclude medical records from the definition of "public records" open for public inspection.

Electroconvulsive Therapy. Senate Bill 209 (Roberto, D-Ravenna) amended the law to permit the use of electroconvulsive therapy for patients who are unable to give legal consent and for whom a guardian cannot be located.

ASSOCIATED ACTIVITIES

The Legislative Department participated with the AMA and national medical specialty societies in several successful Federal legislative efforts. The Department worked closely with the College of American Pathologists to stop proposed regulations regarding hospital reimbursement and other regulations concerning laboratory personnel standards. The Department also worked with the American Psychiatric Association to defeat a proposed federal mental patients' bill of rights. Other bills in which OSMA activities made a difference include the defeat of the proposed clinical laboratory licensure revision, drug reform legislation, Medicare revisions and the defeat of eight National Health Insurance proposals. Perhaps most important was our **support** of legislation enacted in October that permits individuals or associations to recover legal expenses from the government if the investigation or litigation that caused the legal expense was "inappropriate." This new law was discussed extensively in the last "Legislative Bulletin."

Associated Activities. The OSMA expanded its commitment to the **OSMA Auxiliary** in 1980 and provided it with hundreds of pages of documents and assisted in the creation of the Legislative Resource Person program. The Auxiliary has worked with the Legislative Department and supplemented OSMA contacts with legislators.

The OSMA Legislative Department developed the **Physician's Guide to Ohio Law.** The Guide provides physicians with a quick reference to laws affecting them. Copies were sent to all OSMA members in October.

The Department produced and distributed a major piece of research on the **Determination of Death,** including citations and analysis of brain death legislation throughout the country. This report is currently being used as the basis for the Determination of Death proposal for the 1981 legislative session.

The OSMA has developed a **computerized Key Physician Program** which will be expanded this next year to include the Auxilian Legislative Resource Person program. A survey developed by the Legislative Department resulted in 500 responses listing physicians' legislative interest areas. Our computer is capable of generating names, addresses, and phone numbers for legislative contacts on particular legislative issues in 1981. This program will be expanded in 1981 to target individual physicians with particular interests in specific legislative geographic areas. This targeting will assist the OSMA in providing technical information to legislators on short notice through home-town constituent physicians. If you misplaced the survey you received this summer, please call the OSMA Department of State and Federal Legislation — we will be happy to send you another.

FORECAST

This week, the legislators returned to face problems left unresolved at the December adjournment. Many of the legislative issues facing the OSMA in 1981 are retreads of similar bills introduced during the past two years. The sponsors of legislative initiatives that failed have studied their strategic or tactical errors and are prepared to begin again. The OSMA **already** knows several of the 1981 legislative issues, including: the OSMA-sponsored determination of death proposal, a redraft of the Emergency Medicine Paramedical Legislation, revision of "Good Faith Efforts" legislation, the revision of CME statutes, abortion legislation, provider reimbursement in the state's welfare budget, allied health practitioner statute revision (including physician assistants, nurses, nurse practitioners, pharmacists, and optometrists, to name just a few), criminal health care liability and expansion of third-party payer powers over the delivery of health care. This abbreviated list represents a small number of **known** charges for this new legislative session, and the Department/OSMA anticipates an untold number of other legislative issues which traditionally arise. A more detailed description of the 1981-1982 legislative issues is included in this issue of the OSMA Journal on page 29.

Despite the increasing demands of both State House and Congressional responsibilities and involvement with new associated legislative activities, the OSMA will continue to work to protect both the public and the physician from the development of ill-advised legislative proposals.

Clearly, this imposing legislative and administrative agenda only lends credence to the political reality that health care issues will continue to dominate our legislature. Accordingly, in spite of the many successes and even in light of the new administration in 1981, physicians can only expect more and more complicated battles in the eighties. The government, third-party payers, and others will continue to encroach upon the practice of medicine and only through the combined efforts of organized medicine and the legislative process can the practice of medicine be protected and survive.



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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by
Karen S. Edwards

Hospitals vs. the new health-care providers

If you've been watching the recent growth of health maintenance organizations, ambulatory surgical centers and urgent care facilities, and wondering how it will affect the hospital as a health provider, Karl D. Bays, chairman of the American Hospital Supply Corporation tells you not to worry.

"There has been growth in some alternative forms of health-care delivery," Bays said, "but the majority of these facilities are either hospital-based or hospital-affiliated. Demand for health care, including demand for the services that only hospitals can provide, will increase during the remainder of the decade."

Demographic trends provide one reason for the growing demand, Bays said. He also cited forecasts that the number of people over age 65 (a group that used three times as much hospital care as those in younger age groups) will grow twice as fast as the overall population during the 1980s.



Impaired professionals

The impaired professional will be the subject of a mideastern regional conference, to be held at the Hilton Inn North, Worthington, Ohio, on March 14-15, sponsored in part by the Ohio State Medical Association.

The conference has several objectives:

- To enable physicians, their families, and those working in the medical profession to identify impaired professionals as early as possible.
- To provide professionals with mechanisms for confrontation, encouraging entry into treatment and reentry into effective practice following rehabilitation.
- To familiarize professionals with special problems including suicide prevention, "workaholic" professionals, and stress within the professional's family.

The conference also is being sponsored by the Ohio Hospital Association, Ohio Nurses Association, Ohio Osteopathic Association, Indiana State Medical Association, Michigan State Medical Society, West Virginia State Medical Association, and Kentucky Medical Association.

Preliminary program and preregistration materials may be obtained from the Department of Health Education, Subcommittee on the Impaired Physician, OSMA, 600 South High Street, Columbus, Ohio 43215 (614)228-6971.

Meetings

CLINICAL CYTOPATHOLOGY FOR PATHOLOGISTS (POSTGRADUATE COURSE): March 22-April 3, the Johns Hopkins University School of Medicine and the Johns Hopkins Hospital, Baltimore, Maryland. Credit: 125 hours Category I. An intensive refresher in all aspects of the field of Clinical Cytopathology, with time devoted to newer techniques, special problems and recent applications. Application to the course must be made before January 28, 1981. Contact: John K. Frost, M.D., 610 Pathology Building, the Johns Hopkins Hospital, Baltimore, Maryland 21205.

THE CHALLENGE OF MODERN CLINICAL NUTRITION: EDUCATION, PRACTICE, RESEARCH: February 2-5, New Orleans Hilton, New Orleans, Louisiana. The latest advances in Clinical Nutrition will be presented. Fee: $140 for members, $175 for nonmembers, $35 for student/resident/intern. Contact: The American Society for Parenteral and Enteral Nutrition, Inc., 1025 Vermont Ave., N.Y., Suite 810, Washington, D.C. 20005, phone 202-638-5881.

If you're still smoking, then you must be . . .

If you have patients with the same complaints as most pregnant women — irritability, nausea, constipation — only the patients are of the **masculine** gender, don't be alarmed, says the latest issue of *Health Insurance News*.

According to Saul Shiffman, Ph.D., and associate director of UCLA Medical School Laboratory for the Study of Smoking Behavior, the above-mentioned complaints are as common to new nonsmokers, as they are to new mothers-to-be.

"Withdrawal symptoms (like the ones mentioned above), start soon, frequently within two hours of abstinence. In the first week, symptoms usually get less severe. But in the second week, symptoms either level off or get worse," Dr. Shiffman said.

He adds that quitting "cold turkey" is best. In general, gradual cutting back is not successful, since, as the smoker cuts down, the body becomes deprived of nicotine and triggers the withdrawal symptoms.

Spotting potential measles outbreaks

The Ohio Department of Health is urging physicians and parents to carefully check measles immunization records, after a recent study by the department revealed that over 250,000 school children in Ohio may still be susceptible to measles because they were immunized *before* their first birthday.

Under the Ohio School immunization law, the only acceptable measles vaccination is that given *after* the child's first birthday, and there is no exception to this requirement.

Ohio's goal of virtually eliminating measles by October 1982 may be jeopardized if these children remain susceptible to measles.

Health department officials state that no unusual reactions have been noted in immunizing children who had previously received live-virus vaccines at less than 12 months old. Both the school immunization law and accepted medical practice specifies reimmunizing children who received their vaccine before their first birthday.

Decaffeinated colas "hit the spot" with consumers



Decaffeinated cola drinks may become a "new beverage for the '80s," should the Food and Drug Administration (FDA) follow through with its proposal to change current rules requiring cola manufacturers to use caffeine in their products.

The change would withdraw the requirement that "cola" and "pepper" beverages contain "caffeine from kola nut extract and/or other natural caffeine-containing extracts," and simply designate kola nut extract, per se, as the mandatory, characterizing ingredient.

The change came about, in part, because consumers felt that requiring caffeine in beverages was contrary to the public health, and argued that the public should be free to choose decaffeinated cola drinks if they wanted them.

MISCELLANEA

• The Center for the Biology of Natural Systems has "put it all together" and come up with a brochure that lists (in one place) all of the human and animal carcinogens that have been found, to date, by various federal agencies. This master list, also known as Bulletin No. 14, gives the chemical names, Chemical Abstract registry number and a reference code telling which agencies rated the chemical as carcinogenic. The brochure is available free from: The Center for the Biology of Natural Systems, Campus Box 1126, Washington University, St. Louis, Mo. 63130. Be sure to send a long, self-addressed, stamped envelope with your request. They say that their mail is overwhelming without such help.

• Physicians who are in charge of their hospital or medical society's disaster planning committee may be interested in obtaining a new 24-minute, 16-mm color motion picture entitled, "Disaster! Pre-Hospital Management of Mass Casualties." The film, distributed by Abbott Laboratories, uses a simulated air disaster to highlight such major planning considerations as: adequate manpower and equipment; command post; communications; medical/triage; transportation and hospital disaster plans. The film is available for a $10 rental charge for a five-day period of use, and comes with ten brochures which detail the film's major points. For more information, or to order, contact: Abbott Laboratories, Audio Visual Services, 565 Fifth Avenue, N.Y., N.Y. 10017.

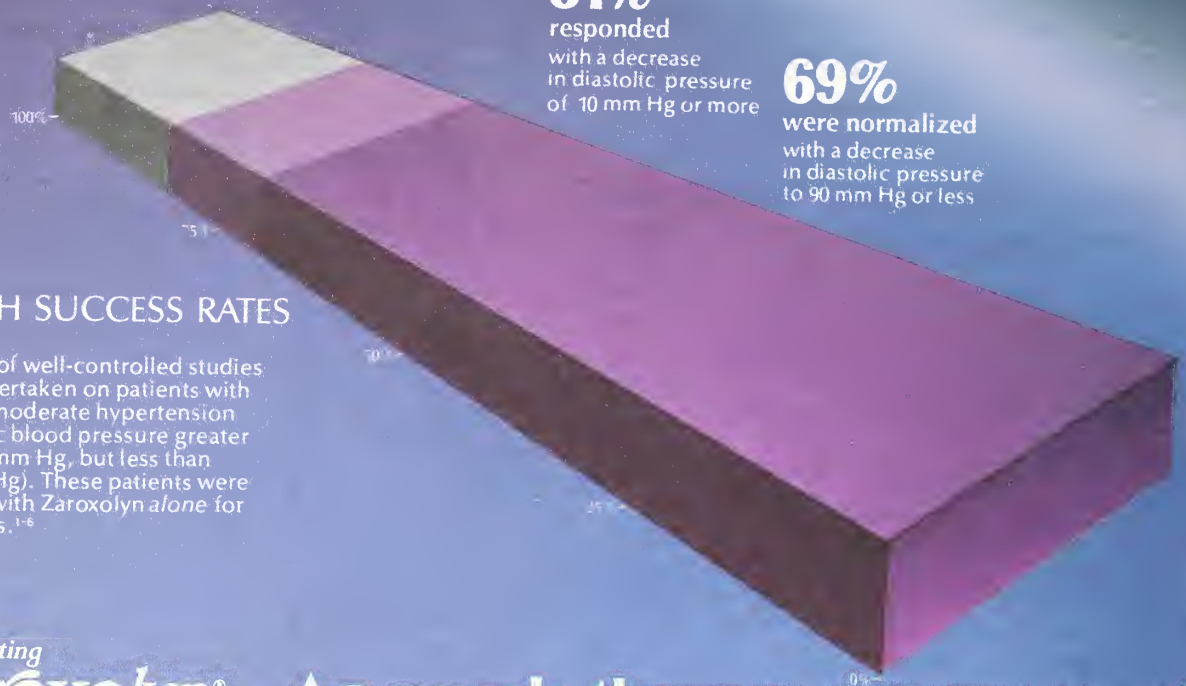
• A useful booklet, "Using Your Medicines Wisely: A Guide for the Elderly," has been published by the National Institute on Drug Abuse. Free single copies are available by writing: Elder-Ed, P.O. Box 416, Kensington, Md. 20795. Multiple copies (in lots of 100) may be purchased for $17 by writing: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

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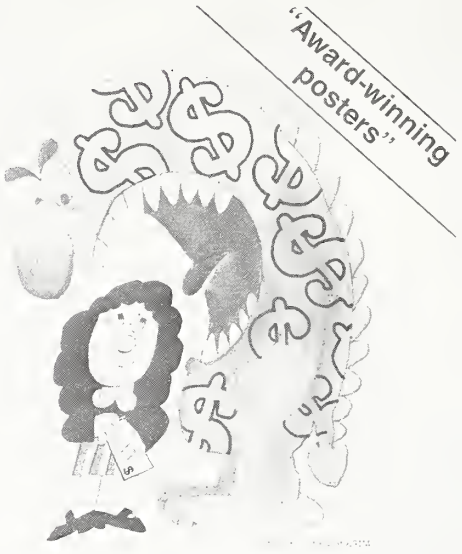
Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of child-bearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaroxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. **2.** Van Hoose MC, Cutler RE: Antihypertensive efficacy of metolazone (Zaroxolyn®) alone and combined with reserpine in treatment of essential hypertension. *Curr Ther Res* 20:266-276, 1976. **3.** Cangiano JL, Campos JA, Trevino A IV, et al: The effects of metolazone in the long-term treatment of essential hypertension. *Curr Ther Res* 16:778-785, 1974. **4.** Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Curr Ther Res* 20:745-750, 1976. **5.** Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18:527-533, 1975. **6.** Materson BJ, Oster JR, Perez-Stable EC: Antihypertensive effects of metolazone (Zaroxolyn). *Curr Ther Res* 16:890-896, 1974.

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Winning ways



OSMA's "Lifestyle" posters depict ways of life that can help control the health-care cost dragon.

Winning may not be everything — but try telling that to OSMA's Department of Communications!

The department recently garnered four awards in district competition (Ohio, Indiana, Michigan) of the International Association of Business Communicators' (IABC) annual communication awards contest.

The *Ohio State Medical Journal* and *Synergy*, OSMA's patient publication, each took second place in their respective categories, and Carol Mullinax, OSMA's Assistant Director of Communications, placed second in a category honoring individuals who produce an entire publication single-handedly.

However, top honors went to the department's "Lifestyle" posters, which took first place in a category honoring special one-time publications. The posters depict assorted lifestyles and the role these lifestyles play in controlling health-care costs.

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SECOND OPINION

Editor's Note

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

Felino V. Barnes, M.D., practices pediatric and adolescent medicine in Middleburg Heights, Ohio.

Tapping the foreign medical graduate source

"The medical profession needs leaders, and there is great potential for leadership in organized medicine among foreign medical graduates."

By Felino V. Barnes, M.D.

The latest statistics reveal that there are some 87,000 foreign medical graduates in the United States, 74,000 of which are licensed in various states. However, only one third of this number belong to the American Medical Association (AMA).

Certainly a substantial membership market is being overlooked. Active and personal recruitment efforts are essential for organized medicine to assure foreign medical graduates that they *are* part of American medicine. One way to do this is to involve non-U.S. medical graduates in activities, committees, and programs at all levels of organized medicine. This would demonstrate goodwill, enhance communication and establish a link between the foreign medical graduate, and his or her American-educated counterpart.

While there are special problems which foreign medical graduates must face, the issues in the practice of medicine are the same for both. The medical profession needs leaders and there is great potential for leadership in organized medicine among foreign medical graduates.

After publication of the report of the Ad Hoc Committee of the AMA — at which time Dr. Sammons reported that non-U.S. medical graduates would be appointed to vacancies on various AMA committees — there was a sudden interest, and an actual increase in membership of foreign medical graduates. When the July, 1980 meeting of the AMA took place in Chicago, however, no such appointments were made.

Non-U.S. graduates are here to stay — and so are their families and their American-born children. They should not be treated as second-class physicians but as equals, and given the same chances and responsibilities as American graduates. As a U.S. citizen, I personally am proud to have been elected a Director of the Academy of Medicine of Cleveland, and to have been involved in many community activities.

Increasing the number of foreign medical graduate members, and involving them as much as possible in local, state and national medical associations will certainly strengthen organized medicine. As the saying goes, "Where there is unity, there is strength." OSMA



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BOOK SHELF

The Battered Child. *Edited by C. Henry Kempe and Ray E. Heffer. The University of Chicago Press, $25.00.*

This is the third edition of the book that, over ten years ago, first identified and detailed the "battered child syndrome."

Now expanded by 23 new chapters, the book in its present form goes beyond the discussion of physical abuse, and focuses on other areas of concern, such as neglect, emotional deprivation and sexual abuse.

Emphasis has shifted from an "after the fact" diagnosis and care of abused children, to the development and application of preventive measures. By recognizing and helping potentially abusive parents, the contributors to this new edition hope to reduce the dismal statistics on child abuse.

The book is available for $25.00 per copy from the University of Chicago Press, 5801 South Ellis Ave., Chicago, Illinois 60637.

Emotional Disorders: An Outline Guide to Diagnosis and Pharmacological Treatment. *By Alberto DiMascio, Ph.D. and Harold L. Goldberg, M.D.: Medical Economics Co.; $13.95.*

Now in its third edition, *Emotional Disorders* is designed to help the nonspecialist health professional recognize, understand and deal with the most common psychiatric problems that can be treated pharmacologically.

Principle chapters cover improved interviewing techniques and the latest methods of diagnosing and treating acute and chronic schizophrenia, neurotic and psychotic depression, and manic and anxiety states. Other chapters discuss the effects of psychotropic drugs in pregnancy, childhood disorders and in geriatrics.

The book is available for $13.95 per copy (plus $1.00 handling charge) from Medical Economics Books, Box 157, Florence, Kentucky 41042.

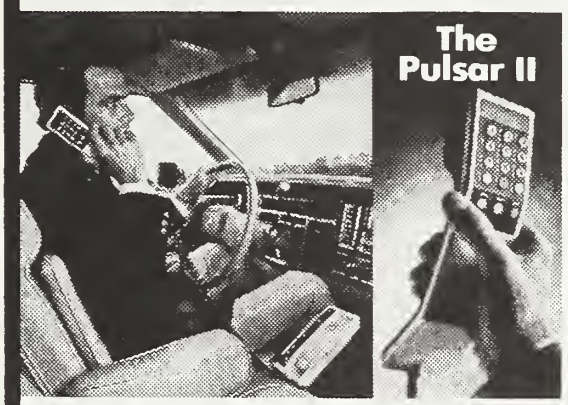
Socio-Economic Factbook for Surgery. *Published by the American College of Surgeons (ACS). Free.*

This 97-page booklet contains descriptive and statistical information on surgical manpower, use of medical services and medical economics.

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The booklet is available free of charge from the Department of Surgical Practice, American College of Surgeons, 55 E. Erie St., Chicago, Illinois 60611.

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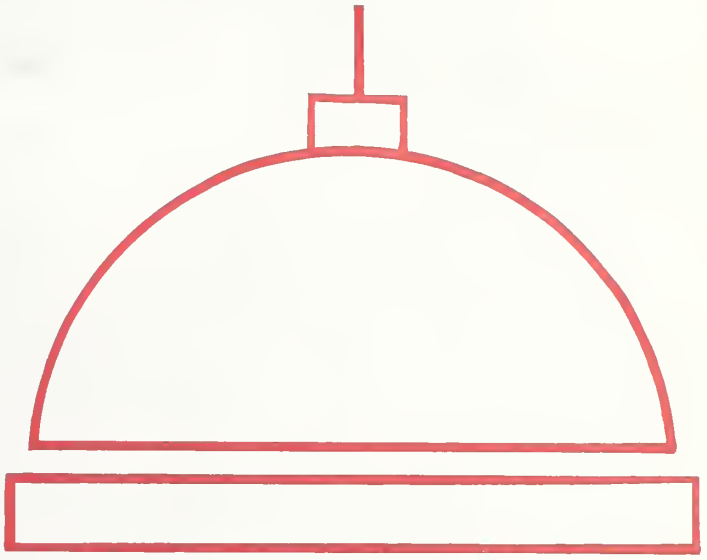


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Politics and Medicine:

The road ahead

By the OSMA Legislative staff



The 114th General Assembly opens this 1981-1982 biennium with a clean legislative slate — a slate that will become increasingly familiar as many issues which failed to pass last session return with new bill numbers. These issues, and some new ones, will be before a legislature markedly different from the 113th General Assembly.

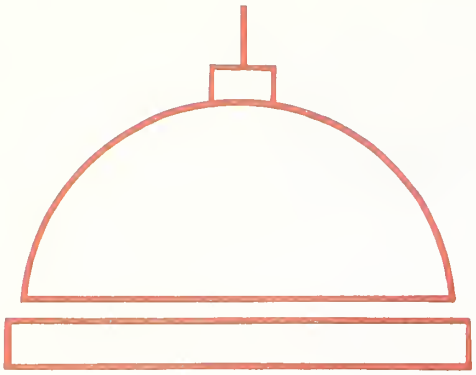
With the Republicans now in control of the Senate, and six new seats in the House, the Ohio General Assembly has managed to achieve a more balanced political makeup than in previous years. Senate Democrat committee chairmanships have become Republican posts, and Republicans have also assumed control of the State Controlling Board, the "purse-string" agency that decides which of the state's financially troubled programs will be helped.

The shift in numbers also had a pronounced effect on leadership structures in both Houses and parties. As expected, the Senate Republicans elected Paul Gillmor (R-Port Clinton) President of the Senate. Thomas Van Meter (R-Ashland) was elected President Pro-Tempore, and Stanley Aronoff (R-Cincinnati) was picked as Assistant President Pro-Tempore.

Reflecting dissatisfaction with the electoral loss of several seats, a slight majority of Senate Democrats replaced the current Senate President, Oliver Ocasek (D-Northfield), and current President Pro-Tempore, Morris Jackson (D-Cleveland), with Harry Meshel (D-Youngstown) as Minority Leader and Neal Zimmers, Jr. (D-Dayton) as Assistant Minority Leader. The other members of the new minority leadership are Charles Butts (D-Cleveland), who will assume the post of Minority Whip in the new session, and Tim McCormack (D-Euclid), who has been given the newly created post of Minority Floor Leader.

In the House, both caucuses voted to keep their current leaders, Speaker Vern Riffe (D-New Boston) and Minority Leader Corwin Nixon (R-Lebanon). However, Majority Whip Francine Panehal (D-Cleveland) was ousted and replaced with Art Wilkowski (D-Toledo), while House Republicans elevated Ben Rose (R-Lima) and Helen Fix (R-Cincinnati) to the Assistant Minority Leader and Minority Whip positions, respectively. The posts were previously held by Bill

With the Republicans now in control of the Senate, and six new seats in the house, the Ohio General Assembly has managed to achieve a more balanced political makeup.



"As (paramedicals) and other groups focus their attention on the Ohio General Assembly in hopes of attaining new professional authority by law, Ohio physicians must communicate . . . the consequences of these issues."

Batchelder (R-Medina) and Donna Pope (R-Parma).

The Ohio General Assembly has been increasingly involved in issues which increase government's regulatory impact upon the health care delivery system. During the 113th General Assembly, more than 200 individual pieces of medical legislation were under consideration by the legislature. These issues can be categorized into two primary areas: (1) paramedical or allied health practitioner and (2) increased or restructured government programs.

PARAMEDICAL LEGISLATIVE PROPOSALS

Throughout the United States, all types of allied health personnel are seeking increased statutory authority to expand their scope of practice. Most paramedical groups use the same arguments for expanded practice definitions: (1) the allied health practitioner can provide the same service as a physician but at a lower cost, and (2) the allied health practitioner is more accessible to the consumer.

Regardless of the rationale used, allied health practitioners seem to be seeking a goal of direct reimbursement by third-party payers via statutory law.

During the 113th General Assembly, several allied health organizations sought such changes in Ohio law. Thanks to the efforts of physicians who communicated with their legislators, the Ohio General Assembly has thus far rejected the allied health practitioner push for new authority and independent reimbursement.

However, hospital admissions, another allied health area of concern, will undoubtedly be considered in the 114th General Assembly. Last year, the OSMA successfully amended the Hospital Licensure Bill (HB 753) to require that all patients be admitted to a hospital by a physician. Limited coadmittance privileges were extended to dentists and podiatrists, in accordance with the standards established by the Joint Commission on Accreditation of Hospitals (JCAH). In addition, the bill stated all patients must be under the medical supervision of a physician.

Despite these setbacks, allied practitioners are expected to make yet another push to turn the acute-care hospital into a general health-care facility, with admitting privileges for all. That's why the consequences of open hospital admissions — as they affect costs and quality of care — must be continually discussed with legislators during this new session.

Another area that's been opened for legislative examination by physical therapists and other individual groups is the matter of removing physician referral requirements, currently mandated by law. This would open the way for mandatory direct payment by third-party payers.

Last year the nursing profession introduced legislation to "update the Nurse Practice Act." This "update" specifically removed the statutory prohibition against nurses diagnosing and treating patients. A parallel issue lies in the expansion of the role of the nurse practitioner, and the nursing profession's hope that Ohio will statutorily sanction independent nurse practitioners.

The optometric profession, too, is likely to continue its efforts to enact a law which would grant them statutory authority to administer drugs and diagnose disease — despite the fact that they are not adequately educated to do so.

Prescribing rights for nurse midwives, as well as statutory endorsement of "lay midwives," are certain to be additional issues confronting the Ohio Legislature this session.

As these and other groups focus their attention on the Ohio General Assembly in hopes of attaining new professional authority by law, Ohio physicians must communicate to their local legislators the consequences of these issues as they relate to quality of care and increasing health care costs.

GOVERNMENT REGULATION AND REORGANIZATION

One of the most fundamental regulators of the medical profession is the State Medical Board. Here in Ohio, the Board has the authority to license, discipline, administer continuing education requirements, and regulate the practice of medicine by both physicians and several allied health professional groups.

Last session, in response to allegations that the State Medical Board is ineffective in its regulation of the medical profession, the OSMA spent considerable time working with the legislature and the Board to increase the Board's effectiveness. However, more physician participation will be needed **this** session, in shaping a law which will give the State Medical Board the tools it needs to regulate the medical profession — and its limited branches — **without** jeopardizing the rights of the practitioner.

The increasing sensitivity of government — as both regulator and payer of health care services — and the escalating costs associated with providing medical care have prompted the state government to take a close look at the structure of Ohio's health care system. A report, published by a select committee of the Ohio General Assembly, examined government's role in the regulation and cost containment of the medical care system. The report rejects such stringent government controls as hospital rate-setting commissions and certificate-of-need for physician offices. Instead, the report encourages "competition" among health care providers through use of incentives and disincentives to hold down costs. The report recommended that third-party payers be required to place certain demands on the medical practitioner — and there's no doubt that the upcoming session will be considering this issue.

A number of insurance proposals that failed to be enacted last session also stand in line for consideration this session. One of these bills proposes to replace the physician-hospital utilization review with utilization review by insurance companies. Another proposes to grant immunity to third-party payers in their investigations of physicians.

While the government increases its demands to third-party payers to hold down costs — insurance companies seem to be more than willing to not only accept those demands, but to assume ever-increasing roles of responsibility which threaten to dismantle the current quality of health care. As arbitrary criteria, established by the third-party payers, become insurance mandates, the private practice of medicine — and its own quality review mechanisms — becomes a thing of the past. Without physician awareness and involvement, this issue alone can pose an overwhelming threat to the present system of medical care. OSMA



The OSMA Legislative staff, pictured left to right, are: Jennifer M. O'Brien, D. Brent Mulgrew, J.D., Eric L. Burkland and Richard A. Ayish.

KEY-PHYSICIAN PROGRAM

As these issues are addressed by the legislature it becomes imperative for physicians to voice their opinions and concerns to their elected officials.

The Ohio State Medical Association Department of State and Federal Legislation has developed a "Key-Physician Program" to serve as a network for contacting elected officials on both the state and federal levels.

Of the 12,500 members who received the Key-Physician questionnaire, approximately three percent were completed and returned. These surveys pinpointed physician interests and potential legislative contacts, enabling the Department to call on appropriate physicians (who know the legislator concerned, or who have a personal interest in the issue) when a particular bill has reached a critical point in the legislative process.

Personal physican contact, through phone calls, letters, or telegrams, has proven invaluable to OSMA's legislative successes in recent years. When approached by physicians, who are both community leaders and medical experts, legislators listen and learn. They are then able to cast intelligent, well-informed votes on complex medical issues. No program with which the OSMA Department of State and Federal Legislation is involved has greater potential effectiveness than the Key-Physician Program. The commitment of a few minutes of a physician's time to guarantee the future freedom to practice private medicine is an investment with an unparalleled yield. Though the economic and political environments facing the Ohio State Medical Association may be unpredictable and uncertain, the OSMA Department of State and Federal Legislation strongly believes that the Key-Physician Program will be a stable and contributing force in formulating public policy affecting the practice of medicine.

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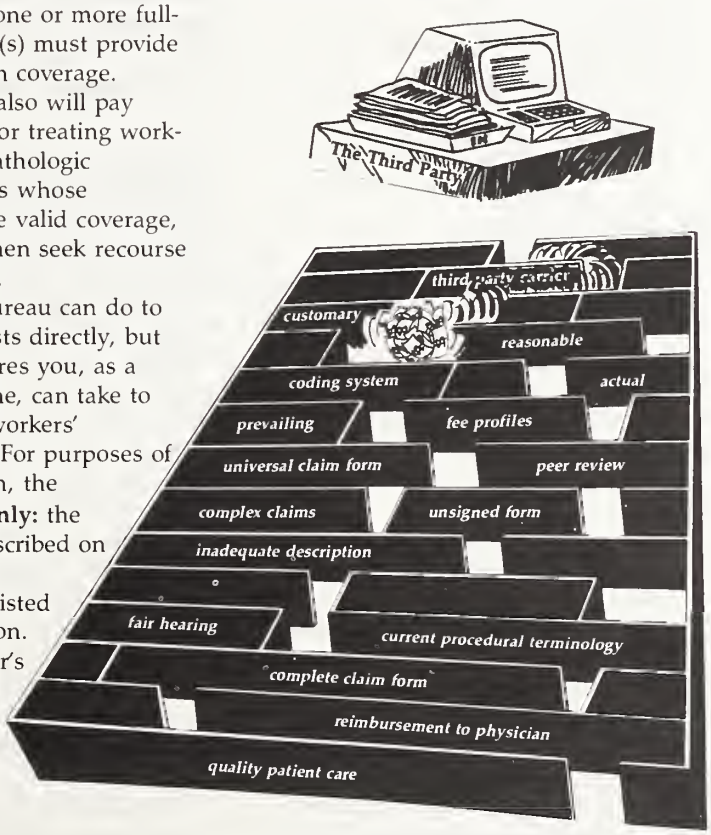
Workers' Compensation

(Second in a Series)

Workers' compensation, for sake of definition, is an insurance program covering employment-related disability — of whatever length — and death. This insurance generally will pay for all necessary and reasonable health-care treatment and medication for modern and competent management of injuries and occupational diseases that occur in the course of, or arise out of, the claimant's employment. Time on the job, salary, nature of work assigned, and age of the claimant are of no significance in determining validity of a claim. Ohio law requires that any employer of one or more full- or part-time employee(s) must provide workers' compensation coverage. However, the Bureau also will pay health-care expenses for treating work-related injuries and pathologic conditions of claimants whose employers **do not** have valid coverage, and the Bureau will then seek recourse against the employers.

There is little the Bureau can do to control health-care costs directly, but there are some measures you, as a practitioner of medicine, can take to help control costs in workers' compensation claims. For purposes of workers' compensation, the physician is to treat **only:** the injury or disability described on the claim application; those body members listed on the claim application. Should the practitioner's treatment of necessity go beyond the limits cited on the claim application, or should the practitioner in good conscience treat the **whole** patient, it is prudent to explain to the claimant which portions of treatment are the responsibility of the Bureau and which, being beyond the confines of a claim, are the responsibility of the claimant.

Verbiage on the claim application may limit treatment that is reimbursable. For example: A worker has a hand crushed and lacerated by a falling piece of machinery. The employer agrees about circumstances of the accident and certifies the claim.



The description of the injury, as cited on the application, is, "lathe chuck fell on right hand, crushing and cutting it." The portion of the body involved is the "right hand." The physician can expect that all necessary treatment and medication for the right hand, as related to this specific injury, will be paid by the Bureau.

However, let us assume that there is also muscle and nerve trauma to the right arm, not known at the time of the accident. The physician, accustomed to treating the whole patient, treats both the hand and arm. In all probability, the Bureau will not pay for treatment to the arm, as trauma to the arm was not mentioned on the claim application, either in the description of injury or the listing of body members involved. Payment for treating the arm may be made by the Bureau, but the physician and claimant will have to execute either a form C-85A, or a form C-86, to petition for recognition that trauma to both the right hand and right arm occurred in a single accident.

Payment or reimbursement for health-care services will be made by the Bureau only if the appropriate claim application is filed. The form you will see most often is the pink, C-3 application, which is initiated for payment of medical expenses only. If the claimant loses eight or more consecutive days from his or her work, the patient/claimant will be asked to file the blue form C-1, and **you** will be sent the green form C-1A. In a small minority of industrial cases, you will be asked to execute a portion of the

standard occupational disease claim application, form OD-1.

While it technically is the responsibility of the patient/claimant to see that the claim application, and any subsequent forms required, are filed, many claimants do not understand this; any assistance you can provide will be most appreciated by the claimant. Your help also may benefit **you** in that it may result in faster payment.

A few weeks after the claim application is filed, the claimant will receive a claim number. It is not advisable for you to file fee bills with the Bureau between filing of the initial claim application and assignment of a claim number, as such interim bills cannot be directed to the appropriate claim file. You should hold bills subsequent to the initial billing until you receive a claim number. From that time, **all** fee bills filed with the Bureau must bear the patient's claim number.

Bureau claim forms

Bureau forms you may see, after filing of the initial application (form C-3), and after you execute a form C-1A, include: the C-17, which is a general bill for pharmacists and others who are not physicians; the form C-19, which is for filing of physician's bills subsequent to the initial billing (this form has been revised to show the estimated return-to-work date at front-top, rather than on the reverse side); form C-84, to petition for continuation of benefits — to be initiated by the claimant, but a portion to be executed by the physician of record. A specific return-to-work date must be given. Terms that do not indicate a specific date, such as **never, permanent,** or **unknown,** will not be accepted. While the physician may believe a specific return-to-work date is unrealistic, additional forms C-84 may be executed serially to extend required recovery time.

It is better to take a few extra seconds to fill out Bureau forms completely than to have them returned for addition of missing information. The initial claim application must include: medical diagnosis; conditions, diseases or injuries being treated; parts of the patient's body affected (**all** parts affected must be listed); identification of treatment; dates of treatment. Any available verification or documentation, such as x-ray interpretations or laboratory reports, should be attached. A new Bureau policy makes inclusion of a payee number mandatory. Bills not having a payee number will be returned unprocessed.

"There are a number of rules with which each practitioner should familiarize himself or herself, to avoid disallowances and disappointment."

Providers should be attentive to any change in name of the patient/claimant, as through marriage or divorce. If such change of status occurs during the course of treatment, both earlier and latter names should be mentioned to prevent confusion to claims examiners at the Bureau, and to prevent ensuing delay.

Some physicians have noted slowness in the Bureau's complying with requests for authorization, so that patients must be admitted in good faith that authorization will be forthcoming. Use of form C-47 to request advance authorization will accelerate the procedure and hasten timely payment.

Generally speaking, a health-care provider can expect payment for any service that is appropriate and related to the recognized and allowed disability, within that practitioner's license to practice. There are, however, a number of rules, with which each practitioner should familiarize himself or herself, to avoid disallowances and disappointment. If the practitioner adheres to the rules, and if claim applications and subsequent billings are executed completely and accurately, payment will be made as expeditiously as the system permits. **It is when irregularities and deviations are introduced by the provider or claimant that most delays in payment occur.** Common provider-initiated irregularities include: multiple billings; incomplete billings and claim applications; change of physicians without obtaining prior authorization; billings for services involving two or more physicians, or use of assistants, etc., if such billings do not include explanation as to why assistants, consultants, specialists, or additional physicians were needed.

Statute of limitations

Health-care providers should familiarize themselves with statutes of limitation imposed by workers' compensation law, to prevent possible financial loss. The claimant has two years from date of injury to file a claim, and two years from approximate date of onset or diagnosis to file an occupational disease claim. Health-care bills will then be paid for six years, if the claim is recognized and allowed, even if the patient never receives compensation for time lost from work. If the patient **has** received compensation as a result of time lost from work, health-care bills will be paid for ten years after the latest action in the claim. All bills from providers must be submitted within two years of date of service; bills submitted after two years will not be paid.

If a patient is treated for an industrial claim and the claim is not allowed, or if the claim is later

disallowed, or if the statute of limitation has expired, payment of outstanding health-care bills falls upon the patient. Under such circumstances, the Bureau is not responsible for making payment.

Providers often wonder about fees to charge in workers' compensation claims. While some complain that the Bureau does not have a hard-and-fast fee schedule, others realize that this flexibility has been maintained in the interest of health-care providers. The Bureau attempts to allow charges for services that are fair and reasonable standards for the geographic area in which treatment is rendered. For example, the statewide average for a specific procedure usually is lower than the typical fee for that service in the Cleveland area, and the Bureau may allow a higher fee from Cleveland. Drug-fee bills are determined through an equation, the base for which is the monthly wholesale price list for drugs published by the Kauffman-Lattimer Wholesale Drug Company in Columbus.

Guidelines available

That generally summarizes the rudiments of billing the Bureau for health-care services and medication. Workers' compensation, as any other form of insurance, has provisions for dealing with exceptions to the rule. Both the generalities and exceptions for filing fee bills are explained in the Bureau's publication **Medical Guidelines,** PA150, free to providers upon request, from Office Services, Bureau of Workers' Compensation, 246 North High Street, Columbus, Ohio 43215. OSMA

The *Journal* expresses its appreciation to Robert A. Dell, Assistant Director of Public Affairs, Ohio Bureau of Workers' Compensation, for his help in assembling this article.



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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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CONTINUING EDUCATION PROGRAMS

January

THE PATIENT WE ALL SEE — COMMON PROBLEMS IN OFFICE PRACTICE: January 21, 1981; Lutheran Medical Center, School of Nursing Auditorium, Cleveland; sponsor: LMC Foundation; 6 credit hours; fee, $50, no charge for residents and interns; contact: Mrs. B. Seidenwand, Office of CME, 2609 Franklin Boulevard, Cleveland 44113, phone: (216)696-4300, Ext. 329.

CURRENT PROBLEMS IN GYNECOLOGY: January 21: Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland; sponsor: Cleveland Metropolitan General Hospital; cosponsor: Case Western Reserve Medical School; 7 credit hours; fee: $75, $35 for students or physicians-in-training; contact: M. J. Thomas, M.D., Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland 44109, phone: 216/459-5890.

March

UPDATE ON COMMON CANCERS: LUNGS-BREAST-COLON: March 11; Greene Memorial Hospital, Xenia; sponsor: Wright State University School of Medicine; 7 credit hours; fee: $25; contact: Ms. Arlene Polster, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

PEDIATRIC UPDATE - 1981: March 20-21; Quaker Square Hilton Inn, 135 South Broadway, Akron; sponsor: Children's Hospital Medical Center of Akron; 11 credit hours; fee: $75; contact: Max E. Griffin, M.D., 281 Locust Street, Akron 44308, phone: 216/379-8790.

CURRENT MANAGEMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE: March 25; Imperial House South, West Carrollton; sponsor: Wright State University School of Medicine; 6 credit hours; fee: $45 Wright State Faculty, $55 others; contact: Ms. Arlene Polster, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

April

MANAGEMENT OF THE DIZZY PATIENT: April 8; Daytonian Hotel, Dayton; sponsor: Wright State University School of Medicine, Department of Otolaryngology; 7 credit hours; fee: $50 Wright State Faculty, $65 others; contact: Ms. Arlene Polster, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

ONE DAY SEMINAR ON GYNECOLOGIC SURGERY & ONCOLOGY: April 16; Carrousel Inn-Silver Room, 8001 Reading Road, Cincinnati; sponsor: University of Cincinnati Medical Center; 6 credit hours; fee: $75, $35 for residents; contact: Raymond Gallagher, University of Cincinnati, College of Medicine, Department of OB/GYN, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4796.



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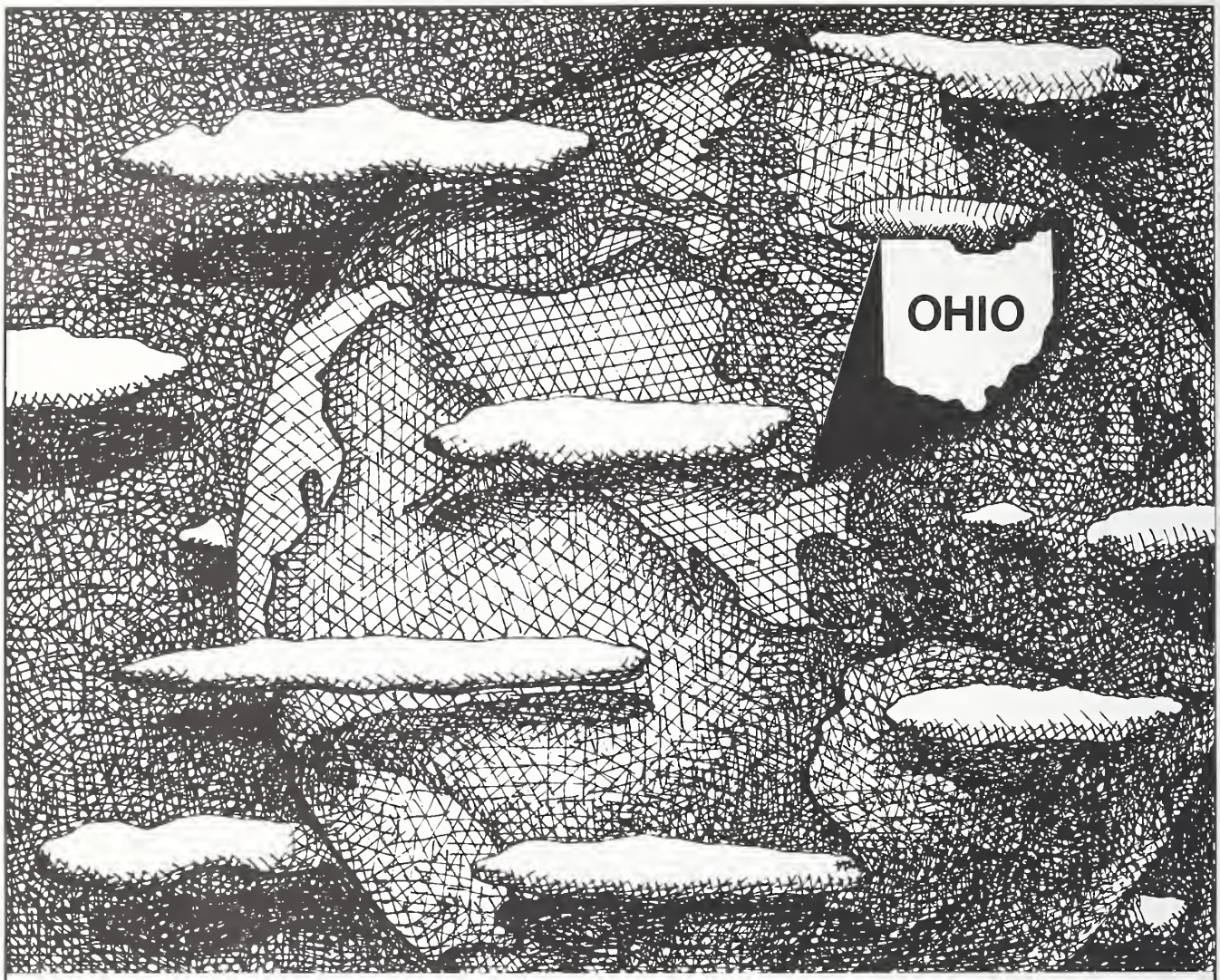
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Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

Obituaries

JOHN C. FENTON, M.D., Cincinnati; University of Iowa College of Medicine, Iowa City, 1956; age 49; died October 27; member OSMA and AMA.

MARION DAY GAMBLE, M.D., New Holland; Ohio State University College of Medicine, 1925; age 84; died 1978; member OSMA and AMA.

RICHARD GARSTER, M.D., Upper Sandusky; Ohio State University College of Medicine, 1931; age 78; died October 20; member OSMA and AMA.

AUSTIN H. HAMMOND, M.D., Dayton; University of Rochester School of Medical Dentistry, 1950; age 60; died September 25; member OSMA and AMA.

WILBUR R. HODGES, M.D., Cleveland; Ohio State University College of Medicine, 1937; age 74; died October 15; member OSMA and AMA.

HENRY F. KULLE, M.D., Cincinnati; St. Louis University School of Medicine, 1928; age 78; died October 20; member OSMA and AMA.

EDGAR KAUFFMAN, M.D., Ravenna; Ohio State University College of Medicine, 1929; age 91; died October 4; member OSMA and AMA.

RALPH H. LEYRER, M.D., Hamilton; Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania, 1938; age 66; died October 4; member OSMA and AMA.

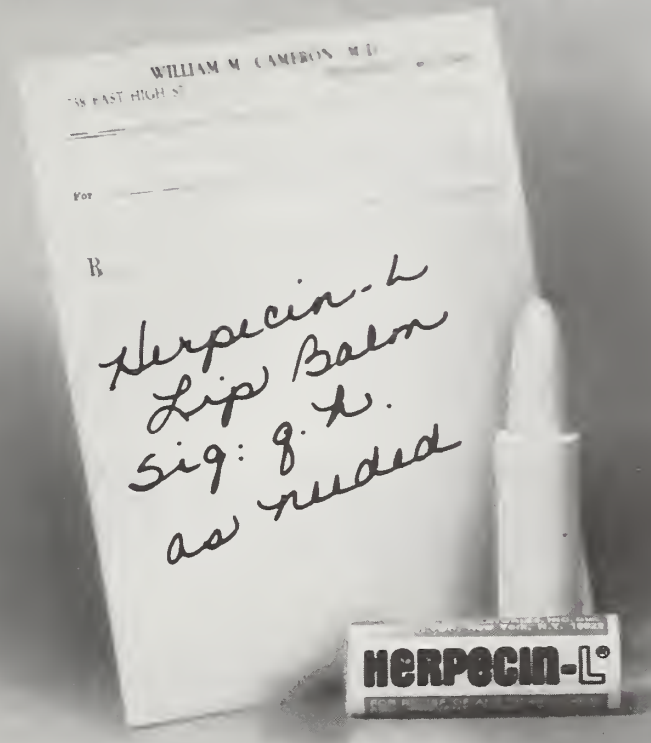
CHESTER LOWENDORF, M.D., Youngstown; University of Michigan Medical School, Ann Arbor, Michigan, 1927; age 77; died October 2; member OSMA and AMA.

CHARLOTTE RHOMBERG, M.D., Veterans Administration Center, Wood, Wisconsin; Rush Medical College, Chicago, 1942; age 63; died October 1; member OSMA and AMA.

HAZEL L. SPROULL, M.D., West Union; University of Cincinnati College of Medicine, 1928; age 81; died September 29; member OSMA and AMA.

GEORGE H. STEELE, M.D., Worthington; University of Michigan Medical School, Ann Arbor, Michigan, 1956; age 50; died November 4; member OSMA.

Dx: recurrent herpes labialis

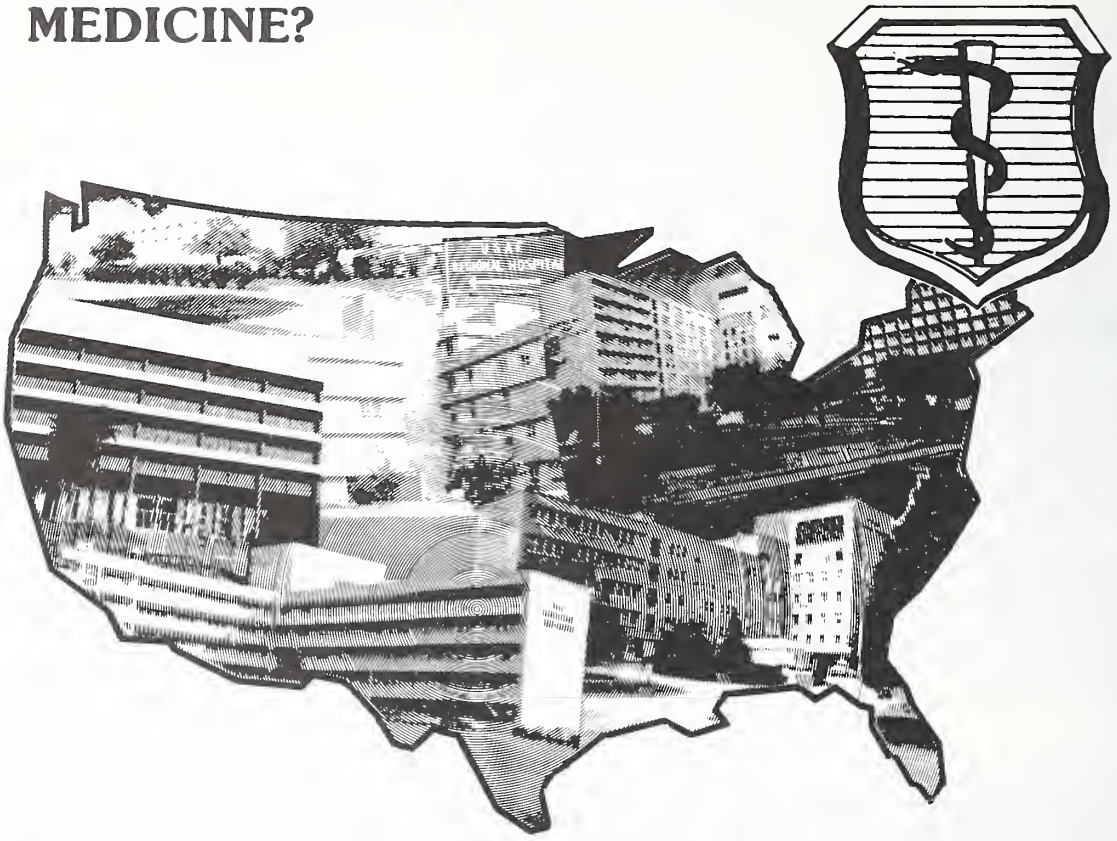


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council proceedings

PROCEEDINGS OF THE COUNCIL

November 15, 1980

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, November 15, 1980, at the OSMA Headquarters Office, 600 South High Street, Columbus, Ohio.

Those present were: Robert G. Thomas, M.D., Elyria; Stewart B. Dunsker, M.D., Cincinnati; Thomas W. Morgan, M.D., Gallipolis; David A. Barr, M.D., Lima; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; William Dorner, Jr., M.D., Akron; John H. Budd, M.D., Cleveland; Oscar W. Clarke, M.D., Gallipolis; W. J. Lewis, M.D., Dayton; James E. Pohlman, Esq., Columbus; George N. Bates, M.D., Toledo; Max D. Graves, M.D., Springfield; Joseph K. Gilmore, PICO; and Jane Lee, AMA.

Those present from the OSMA staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Robert E. Holcomb; Gail E. Dodson; Richard A. Ayish; Rebecca J. Doll; David C. Torrens; David W. Pennington; Eric Burkland; Michael Bateson; and Jennifer O'Brien.

ANNOUNCEMENTS BY PRESIDENT THOMAS

The president announced the following committees:

OSMA Environment Liaison Committee — Samuel R. Lowery, M.D., Fremont, Chairman; Dudley F. Briggs, M.D., Columbus; Stanley E. Broadnax, M.D., Cincinnati; C. William Keck, M.D., Akron; Bruce P. Meyer, M.D., Columbus; S. Theodore Pinsky, M.D., Toledo; Paul P. Rega, M.D., Toledo.

OSMA Committee on Art & Culture — Harry H. Fox, M.D., Cincinnati, Chairman; Victor C. Laughlin, M.D., Cleveland; James G. Ravin, M.D., Toledo; Ludolph H. van der Hoeven, M.D., Dayton.

Dr. Thomas introduced Jane C. Lee, Assistant Director, Office of Medical Society Relations, American Medical Association.

SEPTEMBER COUNCIL MINUTES

The minutes of the September 13, 1980 Council Meeting **were approved.**

Executive Director Report — Mr. Page presented the report of the Executive Director.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Membership Task Force — Dr. Morgan, chairman of the Membership Committee, reported to the Council on Recruitment Activities implemented by the Task Force.

Mrs. Wisse announced increases in both OSMA and AMA members. The Council reviewed statistics which have evolved from the current membership campaign.

Dr. Thomas discussed membership potential for medical students and resident physicians.

Committee on Auditing and Appropriations — Dr. Dorner, acting chairman, presented the November 14, 1980 minutes of the Committee on Auditing and Appropriations.

The Council **approved** expenditure of about $4,000 to remodel offices in the membership department to provide for improved space utilization.

Approved was the retention of Elford, Inc., to act as a troubleshooter for difficult building maintenance problems, on a cost plus basis.

A reimbursement to the Mahoning County Medical Society for assistance with litigation costs **was approved.**

The appointment of a committee of the last three past-presidents to investigate and recommend appropriate reimbursement of the four officers **was approved.**

The tape-to-tape data entry system proposal was discussed and the committee recommended that the staff continue to pursue investigation of tape-to-tape billing, its feasibility for other third-party programs, other methods, etc.

It was agreed to supplement expenses of up to 12 students attending the AMA meeting in San Francisco, up to $150 each.

The Council adopted a motion to request the Committee on Auditing and Appropriations to move up the budget process in order to give more time for input and examination.

Treasurer's Report — Dr. Barr presented the report of the treasurer. It was received for information.

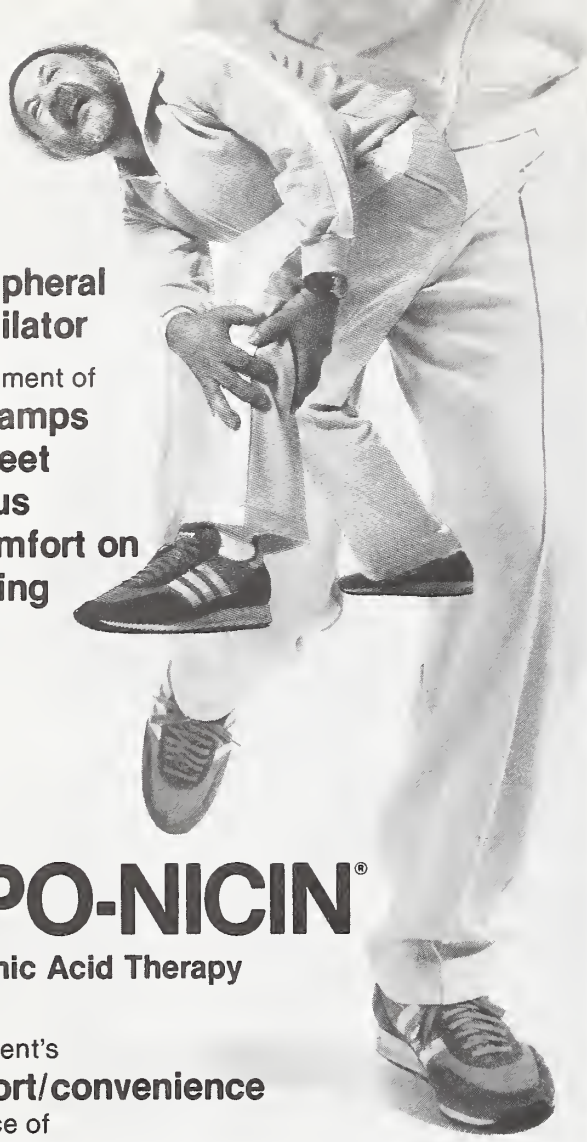
DEPARTMENT OF CONTINUING MEDICAL EDUCATION

OSMA/OHA Joint Task Force on Hospital Emergency Capabilities — Mr. Torrens presented, for information, the minutes of the October 1, 1980 Task Force on Hospital Emergency Capabilities meeting.

Dr. Hickson was appointed by Dr. Thomas as the Council representative on the Task Force and as a member of the OSMA Committee on Emergency and Disaster Medical Care.

The OSMA Annual Meeting — Mrs. Dodson presented a progress report on the OSMA Annual Meeting and reviewed the OSMA new physician workshops.

Committee on Education — Mrs. Dodson presented the minutes of the Committee on Education meeting of



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Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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November 12, 1980, and they were received for information.

Task Force on Interim Sessions — Dr. Dunsker presented the report of the November 14, 1980 meeting of the Ad Hoc Task Force on Interim Sessions. The report was received for information.

Task Force on OSMA Structure — Dr. Dunsker presented the report of the November 14, 1980 meeting of the Task Force on OSMA Structure.

The Council **approved** the following recommendations of the committee:

1. That OSMA not request an ASAE review at this time.
2. That OSMA not request a review of the OSMA structure by an outside firm at this time.
3. That the president be authorized to appoint a Long-Range Planning Task Force with the duty to refine, monitor, and stimulate the implementation of the long-range planning goals of the OSMA.

DEPARTMENT OF GOVERNMENT MEDICAL CARE

Health Planning Update — Mr. Pennington reported on developments in the area of health planning and appropriateness review.

A proposal for a Committee on Health Planning **was approved** by the Council.

Committee on Cost Effectiveness — Dr. Pfahl, chairman, presented the minutes of the November 14, 1980 meeting of the Committee on Cost Effectiveness. The minutes were filed.

Fiscal Disincentive Programs — The Council discussed the fiscal disincentive program of the Hospital Care Corporation as enunciated in its letter of August 29, 1980.

The Council recognizes that controlling costs of medical care is a major problem. In addition, the Council stated its disapproval of inappropriate hospital admission on any day.

However, it was the expression of the Council that the August 29, 1980 letter from Hospital Care Corporation

(Blue Cross of Southwest Ohio) is inappropriate and will lead to poor medical care.

It was voted to contact Hospital Care Corporation and to request it to remedy the situation; to take appropriate action, if necessary, and to keep the OSMA membership informed of developments.

DEPARTMENT OF ORGANIZATION SERVICES

Ad Hoc Committee to Review House of Delegates Policies — The minutes of the October 19, 1980 meeting of the Ad Hoc Committee to Review House of Delegates Policies were presented by Mr. Campbell.

The Council requested that the recommendations be forwarded to the House of Delegates.

With regard to Resolution No. 20-79, the Council **approved** implementation of the resolution in accordance with the intent of the resolution, as outlined by the Committee.

The report was filed.

American Medical Association — Dr. Clarke, Dr. Lewis, and Dr. Budd reported for the OSMA delegation to the American Medical Association and discussed national problems of medicine and activities of the American Medical Association.

Physicians Insurance Company of Ohio — Dr. Bates, chairman of the PICO Board of Directors, addressed the Council.

The question of reimbursement to members of the PICO Board of Directors came before the Council, with regard to the vote on this issue by the holder of Class B shares at a special shareholders meeting.

The matter was addressed by Mr. Gilmore, expressing a positive recommendation of PICO management.

A motion to instruct representatives of OSMA to vote the Class B shares in favor of reimbursement of members of the Board of Directors passed on roll call vote. Drs. Thomas, Dunsker, Morgan, Abromowitz, Diller, Payne, and Dorner abstained.

A motion to instruct representatives of OSMA to vote the Class B shares in favor of a proposed stock split 2 for 1 at a special shareholders meeting was passed.

DEPARTMENT OF HEALTH EDUCATION

Committee on Mental Health — Dr. Max D. Graves, chairman, presented the minutes of the October 12, 1980 meeting of the Committee on Mental Health.

The Council **approved** the recommendation of a subcommittee to promote physician education concerning the treatment of the chronically mentally ill.

The Council postponed temporarily a recommendation for endorsement of the Ohio Psychiatric Association Consumer Education Program on Insurance for Mental Illness.

Referred by the Council to the Committee on Legislation was the suggestion that OSMA urge legislative and executive branches of state government to cancel budget reduction for the Department of Mental Health and Mental Retardation.

The report was filed.

OSMA/ONA Liaison Committee — Mr. Clinger presented a report of the October 16, 1980 meeting of the OSMA/ONA Liaison Committee, recommending a program "Working Together Under the Practice Acts" for presentation at the 1981 annual meeting. The recommendation **was not approved.**

DEPARTMENT OF STATE AND FEDERAL LEGISLATION

Mr. Mulgrew presented a report of the Department of State and Federal Legislation and reviewed the November 4 election from both national and state levels.

Mr. Ayish presented the State Legislative report.

Mr. Burkland reviewed the Association "key physician" computer program plans for 1981.

Jail Project Report — Mr. Ayish reported on the AMA Jail Project meeting which he and Mr. Bateson attended.

COMMUNICATIONS DEPARTMENT

Ms. Doll discussed the Focus Group Interviews report developed from sessions held throughout the state during late summer and fall.

Communications Committee — Ms. Doll presented the minutes of the October 8, 1980 meeting of the Communications Committee.

The Council **approved** the following recommendations of the committee:

1. That a study be conducted to determine factors involving competition and marketing in the health care delivery system, especially as it pertains to future impact on



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MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

delivery of care by physicians. The study is to be completed no later than March 1.

2. That a model media relations program be developed for use by county medical societies and that the model program be developed by choosing a specific county to serve as a pilot project.

Synergy — Ms. Doll stated that the **Synergy** high school health program is underway and that 400 requests for this program have been received.

The Council requested a preliminary report on marketing of physicians' services at the December meeting.

FIELD SERVICE DEPARTMENT

Mr. Holcomb presented the field service report and distributed 50-year awards for presentation in the districts.

COUNCILOR REPORTS

The Councilors reported on the activities in their respective districts.

LEGAL COUNSEL REPORT

Mr. Pohlman presented the report of legal counsel.

CONSTITUTION AND BYLAWS

The Council **approved** the amendments to the Constitution and Bylaws of the Academy of Medicine of Toledo and Lucas County conditionally on their approval at the Academy's annual meeting.

There being no further business the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

Psychiatrists in short supply

Psychiatrists will be in short supply in the future, despite a projected physician surplus, states a study recently conducted by the U.S. Department of Health and Human Services (HHS).

The Graduate Medical Education National Advisory Committee (GMENAC), a 19-member panel, was charged with advising the HHS Secretary on the number of physicians required in each specialty to bring supply and requirement into balance.

It found that general and child psychiatrists will fall short of projected requirements by 12,900 M.D.s in the year 1990. By contrast, the medical profession, as a whole, will be flooded with some 70,000 surplus practitioners by then.

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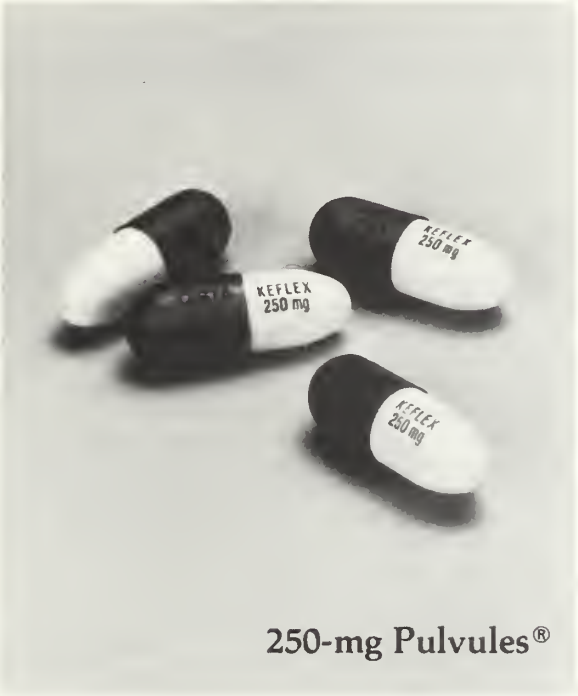
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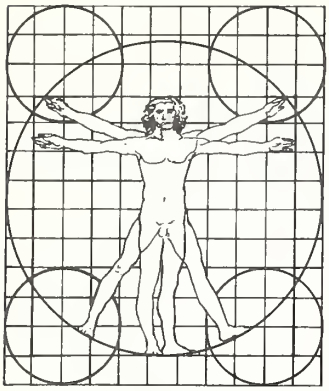
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CLINICAL & SCIENTIFIC

MANAGEMENT OF HEPATIC TRAUMA IN 67 PATIENTS

Gary A. Birken, M.D.
Larry C. Carey, M.D.

Of 67 patients treated for hepatic trauma between 1972 and 1978, 78% had multiple associated injuries. Bleeding was controlled in one third of the patients by conservative local measures, and resection was necessary in only 11 patients. Six died, all with multiple injuries, two dying intraoperatively of unremitting hemorrhage. There is no single best approach to the treatment of liver injury, but increasing experience suggests that rapid correction of hypovolemic shock with various hemostatic technics improves survival. When hemorrhage persists, the location and extent of the injury will determine the appropriate use of hepatic artery ligation, wedge resection, or anatomic or nonanatomic resection. Careful monitoring is required to detect postoperative complications promptly.

MASSIVE HEMORRHAGE FOLLOWING severe liver injury results in a mortality rate as high as 40% to 60%, therefore, the management of hepatic trauma constitutes a formidable surgical challenge. Securing intraoperative hemostasis often requires all of the surgeon's knowledge and skill. However, partly because of the growing incidence of vehicular accidents and violence in our society, hepatic injuries have increased, and additional experience has fostered more effective technics for dealing with this problem.

We reviewed the hospital charts of patients treated for hepatic trauma at The Ohio State University Hospitals between 1972 and 1978, to analyze the mode of treatment, nature of the injury, delay in reaching the hospital, intraoperative findings, hemostatic technics, complications, and mortality.

Patients and Methods

Sixty-seven patients were treated for hepatic trauma between 1972 and 1978; 41 were men and 26 women, and their mean age was 34 years. All patients first were attended in the emergency room, where aggressive methods of resuscitation were initiated. All hospital charts were critically reviewed.

From the Department of Surgery, The Ohio State University College of Medicine, 410 West Tenth Avenue, Columbus, Ohio 43210.
Dr. Birken, Columbus, Resident in General Surgery, The Ohio State University Hospitals, and Clinical Instructor in Surgery, The Ohio State University College of Medicine.
Dr. Carey, Columbus, Robert M. Zollinger Professor and Chairman, Department of Surgery, The Ohio State University College of Medicine, and Medical Staff, Grant Hospital.
Submitted August 12, 1980.

Results

Blunt trauma was responsible for the injuries in 34 patients, while 33 patients had sustained penetrating trauma. The mean time from injury to arrival at the emergency room was three hours. Sixty percent were transported directly to the hospital, while the remaining 40% were brought to The Ohio State University Hospitals after stabilization efforts were made at smaller outlying community hospitals.

Assessed by the usual clinical criteria, 45 patients were in hypovolemic shock upon arrival in the emergency room, and 37 had restoration of normal pulse and blood pressure after rapid administration of 2,000 cc of Ringer's lactate solution. Victims of blunt trauma who met appropriate criteria underwent abdominal paracentesis.

Under direct vision, the peritoneum was incised through a 4 cm infraumbilical incision, and 1,000 cc of normal saline was instilled into the peritoneal cavity. An aliquot of the returned fluid containing more than 100,000 red blood cells was interpreted as positive. Twenty-six of the 30 patients who underwent the procedure showed positive findings. Victims of penetrating trauma with obvious invasion of the peritoneal cavity did not undergo abdominal paracentesis.

When the patient's condition permitted, rapid but thorough evaluation of associated injuries was completed. Seventy-eight percent of patients had multiple associated injuries (Table 1).

Upon completion of appropriate preoperative resuscitation, patients were taken directly to the operating room, where exploration was performed through a midline incision. All patients with penetrating injuries below the fifth intercostal

Table 1. Injuries Associated With Hepatic Trauma

Injuries	No. Patients
Fractures	38
Other abdominal injuries	22
Chest & lung	14
Head	11

space were explored. Only half the patients had spontaneously stopped hemorrhaging, and the only procedures employed were debridement of devitalized tissue and wide drainage. Local hemostatic technics were successful in 20 patients who had continued to hemorrhage. Four underwent wedge resection, an additional four required sublobar resection, and one an anatomic lobar resection. Two patients had wedge resection in concert with selective hepatic artery ligation (Table 2).

Four patients who were actively bleeding at the time of the initial exploration required reexploration for control of recurrent hemorrhage, and all four survived.

Table 3 shows the causes of death. Six patients died as a result of their injuries, and all six had associated injuries. Two of the deaths occurred intraoperatively because of unremitting hemorrhage.

Postoperative complications occurred in 31 percent of patients. The most common were subphrenic abscess, pneumonia, and pleural effusion. Eleven patients had more than one postoperative complication.

Table 2. Control of Hemorrhage From Liver Trauma

Procedure	Number
Compression, suture ligation, electrocautery, hemostating topical agents, hemoclips	20
Wedge resection	4
Sublobar resection	4
Anatomic lobar resection	1
Wedge resection & hepatic artery ligation	2

Table 3. Deaths From Liver Trauma

Concomitant Injuries	Day	Cause
Multiple	28	Cardiac arrest
Multiple	7	Cardiac arrest
Liver only	6	Renal failure
Multiple	3	Cardiac arrest
Multiple	1	Cardiac arrest
Multiple	1	Brain death
Liver only	Intraop.	Hypovolemia
Multiple	Intraop.	Hypovolemia

Discussion

There can be no single best approach to the treatment of liver injury. Most authors have demonstrated that bleeding is not active at the time of laparotomy in 50% to 70% of patients with liver trauma; but in patients who are hemorrhaging, local compression will be extremely effective in most.[1-4] The placing of large sutures to close areas of parenchymal disruptions no longer causing bleeding probably is not necessary. Small vessels may be individually ligated. The most effective local measures include gauze packing,[2] topical hemostatic agents, direct compression, and cauterization. According to the studies of Lucas and Ledgerwood,[3] the incidence of recurrence of bleeding is negligible.

The more aggressive technics must be used by the surgeon when hemorrhage from major blood vessels and hepatic tissue persists. Depending on the location and extent of the injury, hepatic artery ligation, wedge resection, nonanatomic resection, and anatomic resection may be employed. Lucas and Ledgerwood[3] examined 244 patients treated with suturing of the liver in an effort to control active hepatic hemorrhage. One hundred ninety-one survived, and only three required reexploration for recurrent hemorrhage. Fifteen patients subsequently developed parahepatic abscesses.

In the same series, 30 patients were treated with wedge resection and debridement. Twenty-eight survived, and only one had another episode of bleeding. Twenty-one patients underwent formal anatomic resection, and survival was 48%, with one incidence of postoperative liver hemorrhage.

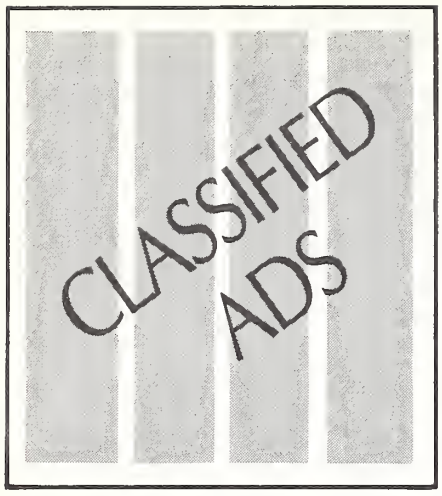
Selective hepatic artery ligation has come under careful scrutiny during the past ten years. Flint and Polk[4] employed selective hepatic artery ligation in 94 of 178 cases of severe hepatic hemorrhage, and were successful in 84% of these patients. Notable complications of this procedure are hepatic necrosis and recurrent hepatic bleeding in the postoperative period. Five of the 15 patients who failed to respond to selective hepatic artery ligation died. The remainder responded to a second surgical intervention. There was one case of hepatic necrosis.

The incidence of liver trauma has risen with the increase of vehicular accidents and episodes of violence. Experience has contributed to a more sophisticated approach to this problem, and this has significantly improved survival. Rapid correction of hypovolemic shock with appropriate administration of fluids and urgent celiotomy are mandatory in the victims of severe injuries.

The surgeon's greatest asset in the successful management of threatened hepatic exsanguination is a thorough understanding of and experience with various hemostatic technics. Postoperatively, patients must be carefully monitored to detect the appearance of parahepatic abscesses and severe pulmonary complications.

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1. Trunkey DD, Shires GT, McClelland R: Management of liver trauma in 811 consecutive patients. Ann Surg 179(5):722-728, 1974.
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3. Lucas CE, Ledgerwood AM: Prospective evaluation of hemostatic techniques for liver injuries. J Trauma 16(6):442-449, 1976.
4. Flint LM Jr, Polk HC Jr: Selective hepatic artery ligation: limitations and failures. J Trauma 19(5):319-323, 1979.



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THE Ohio STATE Medical Journal
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Features

Medicaid Fraud 67
Karen S. Edwards
It's a white-collar crime, and Ohio is one of 31 states where a funded state agency will step in to investigate if a case of fraud is suspected. This month's "On Record" interviews the chief of this agency, Richard A. Waltz of the Medicaid Fraud Control Section of the State Attorney General's office for some insight into the problem of Medicaid Fraud.

Medicaid 73

The third article in our series on "Third-Party Payers" takes a detailed look at the Medicaid system and how it works.

The San Francisco Connection 84

The American Medical Association (AMA) interim business meeting took place in San Francisco last December. This report covers some of the highlights and important issues of that meeting.

OSMA's 1981 Budget: Department Analysis 90

Our Cover

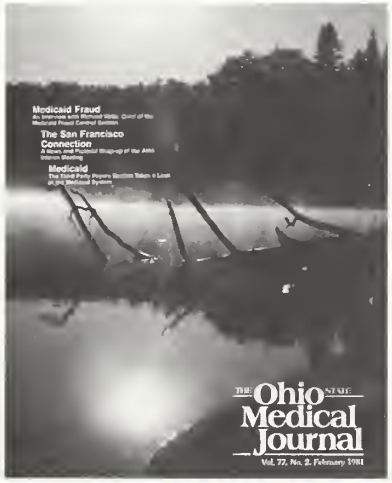
James Rudick, M.D., captured this "Canadian Sunrise" with a Minolta-SRT 101 camera, set at f 5.6, and Kodacolor II film. The picture won an "Outstanding Entry" in the Journal's "1980 Photographic Exhibit" contest.



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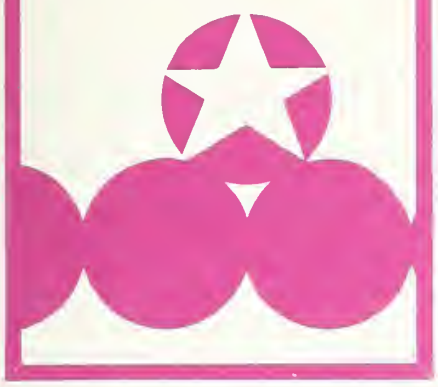
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COLLEAGUES IN THE NEWS



JOSEPH BONTA, M.D., Dublin, was appointed to the Commission on Cancer of the American College of Surgeons. He will serve as liaison between Riverside's cancer program and the American College of Surgeons. Dr. Bonta is director of Riverside Methodist Hospital's Clinical Oncology Program.

CLIFFORD A. JOHNSON, M.D., Akron, was appointed to the American Cancer Society Employee Education Task Force. Dr. Johnson is Medical Director for Goodyear Tire and Rubber Company.

MARK LEVINE, M.D., Shaker Heights, was named chief of the division of ophthalmology at the Mt. Sinai Hospital of Cleveland. Dr. Levine is an assistant clinical professor at Case Western Reserve University's School of Medicine.

EDWARD MANSOUR, M.D., Fairview Park, was appointed to serve as a member of the Cancer Clinical Investigation Review Committee. The committee's primary responsibility is to review protocol studies and grant applications for clinical cooperative investigations in all fields of cancer treatment. Dr. Mansour has been at Cleveland Metropolitan General Hospital since 1965 and has served as director of surgical oncology since 1969. He is also assistant professor of surgery at Case Western Reserve University Medical School.

V. T. MEHTA, M.D., was installed as president of the Aultman Hospital Medical Staff, Canton. Dr. Mehta has been director of laboratories at the hospital since 1975 and also serves as chairman of the department of pathology.

Other officers elected include **ANGELO J. DEMIS, M.D.,** president-elect, and **PAUL W. WELCH, M.D.,** secretary-treasurer.

M.S. RABAA, M.D., was elected member-at-large of the Medical Policy Board and **DAVID M. MONTGOMERY, M.D.,** chairman of the Quality Assurance Committee.

The following were presented certificates for their outstanding service to the hospital and community: **HARRY W. BECK, M.D.,** and **HELEN S. BROGDEN, M.D.,** for 50 years service; **JOHN M. SCOTT, M.D.,** 45 years; **JOHN E. DOUGHERTY, M.D.,** and **ROBERT L. GRAHAM, M.D.,** 40 years; **FRANCIS C. BOYER, M.D., ROBERT K. GARDNER, M.D., EDWARD J. HANLEY, JR., M.D., IGOR F. NIKISHIN, M.D.,** and **ANDREW VEG, M.D.,** 25 years; and **D. DUDLEY FETZER, M.D., HUGH M. PRATT, M.D., CHARAN S. SANDHU, M.D.,** and **LESTER D. SHULTIS, M.D.,** 20 years.

JOSEPH J. PODESTA, M.D., Cincinnati, received Xavier University's Distinguished Service Award. Dr. Podesta has served on the staff of Xavier's McGrath Health Center since 1946 and has taught at the University of Cincinnati since that time. He also maintains a private practice, specializing in internal medicine.

SIDNEY A. PEERLESS, M.D., Cincinnati, was appointed a member of the Planning Subcommittee of the National Advisory, Neurological, Communicative Disorder and Stroke Council. Dr. Peerless also was named to the Research Committee of the American Academy of Facial Plastic Reconstructive Surgery.

WILLIAM R. SCHULTZ, M.D., Wooster, was appointed to the newly created Council of Hospital Governing Boards of the American Hospital Association. Dr. Schultz also will serve on the Executive Committee of that group which will make recommendations to the governing body of the American Hospital Association.

MANUEL TZAGOURNIS, M.D., Columbus, was appointed acting dean of Ohio State University's College of Medicine. Dr. Tzagournis had been associate dean of medicine and associate dean for clinical affairs since 1975 and college secretary since 1973.

EDMOND K. YANTES, M.D., Wilmington, was elected chairman of the Wilmington College Board of Trustees. Dr. Yantes has served as chairman of the Clinton County United Way board, chairman of the trustees of the Wilmington Monthly Meeting (Quaker), was president and a member of the board of trustees of the Ohio Medical Indemnity (Blue Cross), and has been a delegate to the American Medical Association and the Ohio State Medical Association. He is currently chairman of the Friends Community Alliance.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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P.L. 96-499: OMNIBUS RECONCILIATION ACT OF 1980

P. L. 96-499 was the only major Medicare/Medicaid legislation to pass the 96th Congress. In adopting the Medicare/Medicaid provisions of the Reconciliation Act, the key consideration was savings. While it is anticipated that the bill will result in over $600 million in additional spending over the next five years, an expected savings of approximately $2.8 billion should result. The following material details many of the provisions of this enactment and some of the provisions that were considered and not included in the final version of the bill.

Enacted Provisions

Outpatient Surgery. Medicare reimbursement would be authorized for the facility cost of ambulatory surgical centers where the ambulatory surgical center has agreed to accept assignment. This reimbursement would be available in situations where the center performed certain procedures that the Secretary considers "safe" and "appropriate" in an outpatient setting. The physician's reasonable charge for performing the procedures would be reimbursed at 100%, providing the physician also agrees to accept assignment. Also, a physician who accepts assignment will receive additional Medicare reimbursement for performing certain listed surgical procedures, as determined by the Secretary, in his or her office. In this situation, the physician would be compensated for the use of the facility, physician-related services, normal pre- and post-operative visits, routine laboratory, and other diagnostic tests which are usually associated with the procedure performed. Physicians who receive the additional reimbursement for procedures performed in their office will be subject to PSRO review of those procedures, and they must have hospital privileges to perform those procedures to be eligible for special reimbursement under this section.

Reimbursement of Physicians' Services in Teaching Hospitals. This section establishes an alternative form of reimbursement for professional services rendered by physicians in teaching hospitals. Hospitals having approved teaching programs may elect to be paid for the services of those programs on a reasonable cost basis providing that all physicians involved in the teaching program elect to be paid on such a basis. Alternatively, physicians could receive reimbursement directly under the physician payment provisions of Medicare and Medicaid, if the physician renders "personal and identifiable services," and is the patient's attending physician.

Reimbursement of Clinical Laboratories Under Medicare and Medicaid. The payment of the laboratory services will be limited to the lower of the laboratory's reasonable charge, or the actual amount billed by the physician plus a nominal fee to cover his or her costs. If the physician fails to provide the necessary information, the Medicare carrier will estimate and pay the lowest charge at which the service could have been secured by the physician from a laboratory serving the applicable locality.

Determination of Reasonable Charge Under Medicare. In processing Medicare reimbursement, payment will be made on the basis of when the service is rendered, as opposed to when it is billed.

Payments for Radiologists and Pathologists. The special 100% reimbursement, with no deductible, for services to hospital inpatients by radiologists and pathologists would be limited to those who agree to accept assignment for all services furnished to hospital inpatients.

Preadmission Diagnostic Testing. Physicians' services for diagnostic tests performed on an outpatient basis in the outpatient department of a hospital or in a physician's office where the physician accepts assignment within seven days of a patient's admission to the hospital would be reimbursed in full under this provision.

Response of PSROs to Freedom of Information Act Requests. No PSRO will be required to make records available pursuant to a Freedom of Information Act request until one year after the entry of a final court order requiring such disclosure.

Expanded Membership of PSROs. Each PSRO will be authorized to offer membership, at its own option, to nonphysician health professionals who hold independent hospital admitting privileges.

Nonphysician Membership on National Professional Standards Review Council. Membership of this Council would be expanded to include a dentist, a registered professional nurse, and one other nonphysician health professional.

Required Activities of PSROs. A conditionally designated PSRO could become fully designated if it is satisfactorily reviewing services of hospitals. Also, the requirement that the PSRO must, if capable, review long-term and ambulatory care services within two years of becoming fully designated would be eliminated.

PSRO Review of Hospital Admissions, Routine Testing, and Preoperative Stays. This section directs PSROs to give priority to reviewing diagnostic tests routinely provided on admission and elective admissions to hospitals.

Registered Nurse and Dentist Membership on Statewide Council Advisory Group. At least one registered professional nurse and one dentist would have to be included in the membership of the Advisory Group to each Statewide Professional Standards Review Council.

Study of PSRO Norms, Standards, and Criteria. The Secretary would be authorized to conduct a nationwide study of the differences in PSRO's medical criteria and length of stay norms. The intent of this study is to ascertain the basis for differences in norms and ascertain whether steps might be taken to avoid the "perpetuation of inefficiencies."

Consultation by PSROs With Health Care Practitioners. The Secretary would be authorized to establish more flexible guidelines to assure appropriate operational PSRO

consultation with representatives of all health care disciplines. This would replace the present requirement of formal advisory groups to individual PSROs.

Efficiency in Delegated Review. A PSRO is authorized to delegate review functions to hospitals only if those hospitals demonstrate a capacity to carry out the required review effectively, efficiently, and in a timely fashion.

Reimbursement Under Medicaid for Services Furnished by Nurse-Midwives. Under this provision, states would be required to provide coverage under their Medicaid programs for services furnished by a Nurse-Midwife to the extent that the midwife is authorized to perform such services under state law or regulation. Additionally, the Secretary would be authorized to establish standards for Nurse-Midwife participation in Medicaid.

Payment for Physicians' Services Where Beneficiary has Died. The bill would authorize Medicare reimbursement for physicians' services rendered to a Medicare patient before his death, on the basis of an unpaid bill, to an individual who has assumed the legal obligation to pay for the physician's services.

Home Health Services. Major changes in the legislation were agreed to: unlimited home health care benefits would be made available under both Parts A and B; the three-day prior hospitalization requirement would be eliminated; the $60.00 deductible under Part B would be waived; occupational therapy would be added as a benefit criteria; and the state licensing requirement would be waived.

Payment to Providers of Services. Medicare reimbursement to providers of services under Part B would be based upon reasonable cost minus the coinsurance amounts charged the beneficiaries by the provider.

Presumed Coverage Provisions. Medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing facilities and home health services would be repealed.

Optometrists' Services. Coverage for optometrists' services to aphakic patients will be provided under Medicare. Also, a study will be conducted to determine whether Medicare should reimburse optometrist services to cataract patients.

Coordinated Audits Under the Social Security Act. This section allows for the coordination of audit procedures under Titles V, XVIII, and XIX.

Hospitals Providing Long-Term Care Services ("Swing Beds"). The Secretary will be authorized to enter into agreements with certain hospitals under which the hospital can use its beds, depending on need, to render long-term care services. Additionally, this provision deals with setting the appropriate reimbursement rate for hospital patients receiving long-term care services where no "swing bed" arrangement exists.

Medicare Liability Where Payment Can Be Made Under Liability Insurance Policy. This section would provide that Medicare would not be the primary payer in cases where a patient is involved in an accident and his or her care is covered under a liability insurance policy or under a no-fault insurance plan. Under this provision, Medicare would pay for the patient's care in the usual manner, and then seek to be reimbursed by the private insurance carrier.

Quality Assurance Programs for Clinical Laboratories. The Secretary's authority to coordinate the development and application of quality assurance programs with respect to clinical laboratories participating in Medicare and Medicaid and which are subject to federal standards under the Public Health Service Act will be extended for an additional year.

Continued Use of Demonstration Project Reimbursement System. This bill authorizes states with rate-setting programs under demonstration projects to continue to determine Medicaid and Medicare reimbursement rates under those programs unless the Secretary finds that the programs no longer meet applicable standards.

Suspension of Periodic Interim Payment (PIP). Payments to hospitals reimbursed under the PIP method would be delayed so as to equalize the payment delay experienced by hospitals reimbursed under the conventional method. This delay would start on September 1, 1981, and it should be of approximately three weeks' duration.

Nonprofit Hospital Philanthropy. The purpose of this section is to encourage philanthropic support for health care. For the purposes of determining reasonable costs of services under Title XVIII and XIX, unrestricted grants, gifts, endowments, and income therefrom will not be deducted from the operating costs of the provider.

Certification and Utilization Review by Podiatrists. Under this section, consistent with state law, podiatrists would be recognized by Medicare for purposes of physician certification and participation as physicians in utilization review.

Comprehensive Outpatient Rehabilitation Services. This section permits reimbursement under Medicare for comprehensive outpatient rehabilitation facilities under Part B, based on the costs incurred in furnishing covered services, including: physicians' services, nursing care, physical therapy, occupational therapy, speech pathology, respiratory therapy, social and psychological services, prosthetic devices, drugs and biologicals, supplies, appliances, equipment, and other items which are necessary for the rehabilitation of the patient.

Outpatient Physical Therapy Services. The present $100.00 limitation on outpatient services furnished by an independently practicing physical therapist would be increased to $500.00.

Dentists' Services. Services performed by dentists would be covered if those same services are currently covered when performed by a physician. Hospitalization for noncovered dental services will also be covered where the severity of the procedure or the condition of the patient warrants hospitalization.

Studies and Demonstration Projects. The Secretary would be authorized to study or conduct seven demonstrations: coverage for orthopedic shoes; expanded coverage for services of clinical social workers; nutritional therapy for renal disease patients; expanded coverage for respiratory therapy services; 100% reimbursement for second opinions for surgery; home health service coverage of registered dieticians; and a study of costs of various types of foot care.

Flexibility in Application of Standards for Rural Hospitals. The Secretary would be authorized to apply Medicare standards to rural hospitals in a flexible manner to take into account the availability of qualified personnel, the scope of services furnished, and the economic impact of structural standards which would be unreasonable if rigidly applied to a rural hospital (except if the health and safety of the patients would be jeopardized).

Physician Treatment for Speech Pathology Services repeals the requirement that a physician establish a detailed plan of treatment for speech pathology services.

If you have questions or would like copies of the new law, or committee reports regarding it, please contact the OSMA Department of Government Relations. This report was prepared with the assistance of the AMA Washington office.

The 1981
Ohio State Medical Journal
Photographic Exhibit



The Ohio State Medical Journal is sponsoring its fourth annual photographic exhibit and competition. The 1981 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1981 Annual Meeting, Cleveland, where the entries will be displayed.

Photographs may be entered in two divisions: Black and White, and Color. Each division has two categories: General and Scientific.

Entries must be in print form (8″ × 10″ or 11″ × 14″ in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs must be previously unpublished, and right to publish the photograph must be given to the Journal at the time the photograph is entered in the exhibit.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a $5.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.

ENTRY FORM

Name

If Nonmember, Spouse's Name

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City *State*

County *Zip*

Telephone

Information about photograph:
(provide as much as possible)

Camera *Lens*

Speed *Aperture*

Subject *Film Type*

Date *Time of Day*

Title

Division: ☐ B & W ☐ Color
Category: ☐ General ☐ Scientific
Processing/Printing:
☐ Professional ☐ Self

Mail or hand carry the photograph, entry form and $5 entry fee (make checks payable to The Ohio State Medical Journal) to: The Ohio State Medical Journal Photographic Exhibit, 600 South High Street, Columbus, Ohio 43215. All entries must be received no later than March 28, 1981.

I give the *Journal* publication rights to this photograph. I certify that this photograph has not been published previously and that I will not submit it for publication elsewhere pending the judging of the photographic exhibit. Also, I certify that any person(s) pictured have given me authorization to allow publication of his/her photograph. I also understand that if my photograph is selected for a Journal cover, it may be cropped to meet printing specifications.

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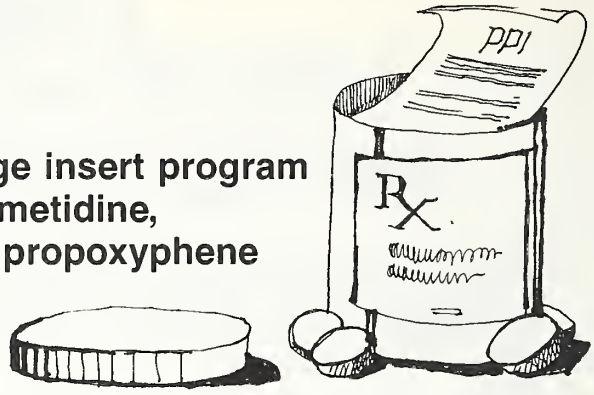
a compilation of the latest developments, reports and products of interest to physicians.

edited by Karen S. Edwards

Summer seminars set

The National Endowment for the Humanities will sponsor a series of seminars this summer, one of which will be aimed toward physicians, nurses, and health practitioners and another which will be specifically directed toward medical and health care teachers. The seminars will be held at selected colleges and universities throughout the country, and will cover a wide range of medical topics. Twelve persons will be selected to attend the seminars tuition-free, and will receive a stipend to cover expenses and travel to the seminars. For applications and further information on the program, write: Professions Program, Division of Fellowships and Seminars, MS-101, National Endowment for the Humanities, Washington, D.C. 20506.

Patient package insert program begins with cimetidine, clofibrate and propoxyphene



Patient package inserts (PPI) for three prescription drugs must be provided to consumers, starting in May, announced Jere E. Goyan, Commissioner of the Food and Drug Administration (FDA). Inserts are to be made available for the following drugs:

- cimetidine — used to treat ulcers
- clofibrate — used to treat elevated fats in the blood
- propoxyphene — commonly sold as Darvon, a pain killer.

This requirement is the FDA's first step in testing the use of patient package inserts for ten prescription drugs. Each insert will detail the drug's proper use, risk, and side effects, and will be given to the patient with each new prescription — and with refill prescriptions, should the patient request it.

Patient package inserts for three other drugs will be required by June, and for four others by July. The FDA will evaluate the PPI program over the next three years to determine whether it should be expanded to include other drugs, or whether an alternative system of dispensing such information should be adopted.

"It is clear that patients want and are entitled to information about prescription drugs. We need to find the best way to provide that information. I call on all health professions to join with us in testing information systems over the coming years," Dr. Goyan said.

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- Feeling tense? Matthew J. Culligan and Keith Sedlacek, M.D., tell you "How To Avoid Stress Before It Kills You" — a new book which takes a detailed look at ways to cope with all those everyday tensions. The authors discuss how the body functions in relation to stress and the use of biofeedback in relieving stress-related complaints. If the thought of buying one more self-help book sets your teeth on edge, though, relax! It's available at the library.

- The W. K. Kellogg Foundation wants to remind you that you have, at your disposal, a veritable wealth of reading material which is printed each year by their Foundation. Everything from Continuing Education to Wholistic Health Centers is included in their periodical library. Interested? Contact the Communications office at the Foundation, 400 North Avenue, Battle Creek, Michigan 49016, for more information.

BOOK SHELF

Diabetes Mellitus, Volume V. *Edited by Harold Rifkin and Philip Raskin, Robert J. Brady Co., $22.95.*

The American Diabetes Association presents another updated version of its thorough and complete reference book on diabetes mellitus, with over 60 top-flight diabetes experts contributing articles on subjects within their areas of specialty. The book reviews the current state of the art in diabetes mellitus, stressing basic physiologic and biochemical mechanisms, and discusses existing and future therapeutic approaches. Each chapter is fully referenced to allow for more in-depth reading, and the book itself features more than 50 illustrations to visually enhance a closer understanding of the subject.

The book is available for $22.95 per copy from the publisher, Robert J. Brady Co., Bowie, Maryland 20715.

Medical Treatment of Venomous Snakebite. *By Martin J. Rosenberg, Ph.D. Published by the Museum of Natural History, in cooperation with the Northern Association of Herptologists, $2.00.*

This 16-page booklet is intended as a guide to assist physicians and other health-care personnel in the proper diagnosis and treatment of bites from venomous snakes of the U.S., with an emphasis on Ohio's venomous snakes.

While it is primarily intended for medical personnel, you may wish to suggest it to those of your patients who are hikers, backpackers, campers, or other individuals who spend time in the field. Reference to the guide can assist the bitten individual in determining whether or not a snake is venomous, and, if so, whether or not the individual has been envenomated.

The guide is available for $2.00 per copy from the Cleveland Museum of Natural History, Wade Oval, University Circle, Cleveland, Ohio 44106.



Learning to speak patient-ese

Physicians may not be saying what they think they're saying!

According to a recent study conducted by seven graduate students at the Case Western Reserve University (CWRU) School of Medicine in Cleveland, Ohio, there appears to be a communication-comprehension gap developing between patients and physicians.

The study asked a total of 58 physicians and third- and fourth-year CWRU medical students to select a response to ten nontechnical phrases commonly used in doctor-patient dialogues, which most closely reflected their personal interpretation. Their responses were compared to those of 70 potential patients from Northeastern Ohio.

"The results," said Marcia Z. Wile, Ph.D., the project's director, "indicated considerable variability with each group, and some statistically significant differences between the responses."

For example, almost half of the physicians and patients took the response "going home from the hospital soon" to mean two to four days. Of the remaining half, however, three patients to every physician translated this phrase as "tomorrow." Patients seem to agree with the physicians that the phrase "if you have a reaction" means "if something unexpected happens" — but if the physician says "if you have trouble, call me," 8% of the patients participating in the survey felt they had just received a "medical brush-off." In fact, only 30% of the patients who responded to the phrase agreed with the 60% of the physicians who thought this mean "if the treatment doesn't work and you get worse, call me."

The most misinterpreted phrase is "it will only hurt a little," with interpretation ranging from a "quick pinch" and "some discomfort" (responses usually chosen by the physicians), to the 24% (largely comprised of patients) who felt "it will probably hurt a lot."

Although some physicians refused to make appropriate choices on some phrases, explaining that they never used such terms in patient communication, only one out of the 70 patients noted that his or her physician never used any of the selected phrases.

"At no time," Dr. Wile pointed out, "did the patient challenge the questions asked them. They seemed more passive than the physicians answering the survey."

This would seem to indicate, Dr. Wile feels, that patients need to assume more responsibility communicating with their physicians.

"We must encourage patients to ask questions when they don't understand what their physician has said. We shouldn't assume that we're all speaking the same language."

She also urged the design of patient education programs and literature which would encourage patients to become more active in their own health maintenance. Such programs, she feels, would be a positive way to reduce the comprehension gap.

Because communication is a two-way street, however, the study also revealed a need by medical students and practitioners for educational activities that would put an emphasis on precise physician-patient communication.

"Physicians should be asking themselves if they are providing a feedback mechanism to patients. Are they allotting enough time with each patient to reinforce their comprehension?"

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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REFER TO PDR



Medicaid Fraud

By Karen S. Edwards

Editor's Note: Richard A. Waltz is Chief of the Medicaid Fraud Control Section of the State Attorney General's office

The Ohio State Medical Journal: As a means of introduction, could you tell us how this department was developed and why?

Richard Waltz: The Division of Medicaid Fraud was formed in April 1978. It came about as the result of a number of statewide hearings on nursing home abuse, which State Attorney General William J. Brown, conducted through the year 1977. The problem of nursing home abuse had been brought to his attention in his travels around the state, and it was determined that one of the best means to eliminate this abuse was to get into the area of prosecuting Medicaid fraud. In New York, for example, where Medicaid fraud is prosecuted, nursing homes, where substantial abuse had taken place, began to show improvement just one month or so after prosecution.

Here in Ohio, we started filing civil suits back in 1977, against a number of providers throughout the state, using the Federal False Claims Act which prohibits filing false claims with the federal government. At the same time, we promulgated legislation which would give the attorney general statewide original jurisdiction to file civil claims in these matters.

During that time, however, the legislature noticed the growing need for *criminal* prosecution of people who steal Medicaid funds, and, in 1978, they passed a piece of legislation which gave the attorney general the statewide criminal authority to prosecute Medicaid fraud. That's how this division was created.

Journal: How is the department funded?

Waltz: In late 1977, the federal government passed a bill which provided 90% federal funding in this area for three years — specifically for use by state attorney general offices to prosecute Medicaid fraud. So, we were funded with that 90% loan. Recently, Congress passed a law providing 90%

". . .the legislature noticed the growing need for criminal prosecution of people who steal Medicaid funds."



Richard A. Waltz, Chief, Medicaid Fraud Control Section, State Attorney General's office

funding for three full years, and 75% thereafter.

Journal: How many state agencies like this are being funded throughout the country?

Waltz: There are 31 states currently funded by this program. A national association of Medicaid fund control units was formed approximately two years ago. The association helps the different states with problems they may be having in dealing with the Department of Health and Human Services (HHS) in Washington, or with other problems that come up in this field. Currently, I'm president of this association, and we recently helped provide the expertise on the bill which provided additional federal funding for the Medicaid fraud divisions.

Journal: What is the most common form of Medicaid abuse? You've mentioned false claims. Is that the most prevalent form of Medicaid abuse?

Waltz: That's the one mentioned most often because it's the easiest one to prove. Most of our complaints come from the Ohio Department of Public Welfare. They have a unit that looks for aberrations in the billing practices of various providers throughout the state. Most of these are detected through computer print-outs, and, on occasion, from complaints by recipients who question a provider's name on the bill. If the recipient claims he or she has never seen that provider, the unit will look at the provider's records to see if the complaint can be substantiated. If they do note a probability of fraud, then those cases are referred to this department so that we can continue with a full-scope investigation. The only time it's difficult to prosecute one of these false claims is when we have to rely on recipient testimony. Often these recipients are relying on memories of events that happened two or three years ago, and no one really remembers exactly what took place that long ago.

Journal: What are some of the other forms of abuse that you see?

Waltz: Another area which we have not yet gone into totally, but which is of great concern to us, is where unnecessary medical services are rendered.

Journal: Isn't that a touchy area? Who is to say what is medically unnecessary?

Waltz: Of course, if a doctor says something is necessary, I'm not saying it's not necessary. But clinics which treat a number of Medicaid patients are seeing six-year-olds coming in for EKGs on a regular basis, and people receiving entire body x-rays for an employment physical. The physician maintains that because of the type of individual involved and his or her health environment, it's necessary to do a full-scale "treatment" if you will, every time the patient comes into the office. The question is, does a normal-paying patient receive the same kind of treatment — and the answer is no.

Journal: Do you classify Medicaid fraud as "white-collar" crime?

Waltz: We focus on the area of white-collar crime, but I think one of the messages we want to try to get out is that some forms of Medicaid abuse are not entirely in the realm of white-collar crime. Some of it is physical abuse. Too many x-rays, for example, can cause a reaction — perhaps even ill health in a particular individual. Same with too many injections. How many people like to receive injections in the first place? Another area which we would call physical abuse as opposed to white-collar crime is the physician who practices in nursing homes, but who never sees the patient. These physicians come in to take care of 30 or 40 Medicaid patients, but all they do is read the charts, and they never visit or examine the patient. Because there is rapid deterioration in the elderly, the charts may not record a change in condition, which has in fact taken place, and which could be picked up by the physician on examining the patient.

Journal: Can a provider unintentionally commit Medicaid fraud?

Waltz: We have a lot of cases where mistakes are made. Usually, these mistakes are made by office employees who misunderstand the regulations governing Medicaid, or just make mistakes in their recordkeeping. There is a vast majority of cases that we look at where the provider does not end up being charged with fraud. However, sometimes in these cases we do ask that a civil recovery be made, and we may ask them to improve their office procedures. But you can't really commit fraud unintentionally. One of the prerequisites in proving a case is that the intent was there.

Journal: Do you prosecute very many cases where drug abuse has been involved?

Waltz: Yes, drug abuse is a very serious problem in the Medicaid program. There are recipients who can go to doctors' offices on a weekly or monthly basis and receive a wide variety of drugs which would hardly

"One of the messages we want to try to get out is that some forms of Medicaid abuse are not entirely in the realm of white-collar crime."



"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

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be prescribed for just one individual. You will see recipients, over a year's time, receive $7,000-$10,000 worth of drugs from the office of one physician. Then, the question has to be asked — are the physician and the pharmacist working together?

We will also do test shopping — where someone from our department poses as a Medicaid recipient, and goes to a physician with a particular ailment, asking for a certain drug, to see if the provider will prescribe it on request.

"Like everyone else nowadays, the only thing we're really trying to do is to help lower health care costs in this country."



Journal: What about recipient fraud? Are there Medicaid recipients who are defrauding the system?

Waltz: Yes, and perhaps one of the best-illustrated cases of this is the recent conviction of a chief auditor who did commit Medicaid fraud. Recipient fraud does exist, but along this line I certainly don't want to make it sound as if a vast majority of physicians out there are committing Medicaid fraud. Most are honest, and it's just a minority with a rather jaded outlook who are giving a bad name to the medical field. Of course, it also should be remembered that physicians are not the only providers committing Medicaid fraud. We recently convicted the top two psychologists in the state — and there are dentists and nurses and others in the health care field who are also defrauding the system. However, people place a great deal of trust in physicians, and when those few do commit fraud, the whole medical profession gets a black eye.

Journal: With your experience in this area, can you tell us why Medicaid fraud is attempted?

Waltz: It's a complex kind of crime, because the providers who are committing fraud really don't need the money — at least for a day-to-day existence. Probably some of them do it because they don't feel the system pays enough, and they're just taking what should rightfully be theirs. But that's hard to justify, because participation in the program is entirely voluntary. Providers don't have to accept Medicaid patients.

Journal: When convicted of Medicaid fraud, what is the usual sentence?

Waltz: That varies, but one fact remains true. As in all white-collar kinds of crime, the sentences tend to be more lenient than those for street crimes.

Journal: What is the usual procedure when you're investigating a case of suspected fraud?

Waltz: Again, that varies. We investigate anywhere from 100-150 cases of Medicaid fraud per year, and we don't always follow one set procedure. Usually, however, we gather background on dollar amounts billed, we interview the major participants, seek out certain documents relevant to the case, and question witnesses. We might also issue subpoenas for the physician's records. It usually takes two to six months to prove fraud — and, of course, that means that there is some disruption in the physician's office. But our investigations are kept confidential until trial time, and we try to keep a low profile until then.

Journal: Is there any comment you might wish to make in closing?

Waltz: I'd like to try to emphasize that we know there are problems in the Medicaid system, and part of our job is determining what these problems are, and how they can be solved.

Part of the solution might be for providers and their staff to maintain good records, and to call the Department of Welfare if any unanswered questions or problems arise.

The health care field hasn't been policed until recently, but, like everyone else nowadays, the only thing we're trying to do is help lower health care costs in this country. OSMA

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If hospitals must battle for CAT scanners . . . will homes have wars of their own to wage?

A Kansas City physician, John K. Layle, M.D., proposed that if some of the bureaucratic logic were transferred from HEW to the Department of Housing and Urban Development (HUD), we might see bathrooms treated as CAT Scanners. Dr. Layle elaborates:

"First, we would see dazzling government statistics showing there is a nationwide plumbing profligacy which is 'skyrocketing' already intolerable housing costs. For example:

1. The average person uses the bathroom only about one hour in each 24. Therefore, they would say, less than 12 people per bathroom is clearly an unconscionable extravagance.

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"These statistics would lead to 'guidelines.' It is un-American to build more than two houses per block with bathrooms. The other houses can share.

"An HSA-like 'Planning Agency' would be created to force errant home builders into compliance with the guidelines. As with the CATs, the Planning Agency will assert: 'Most people do not really need bathrooms; they just want them as status symbols.'

"People wanting bathrooms will, like hospitals, have to submit 'Certificate of Need' forms which will be processed with agonizing slowness because, like HSAs, the Planning Agency will claim it needs additional funding.

"Neighbor will be pitted against neighbor, just as hospitals are now, competing to see who on the block will be allowed to have a bathroom.

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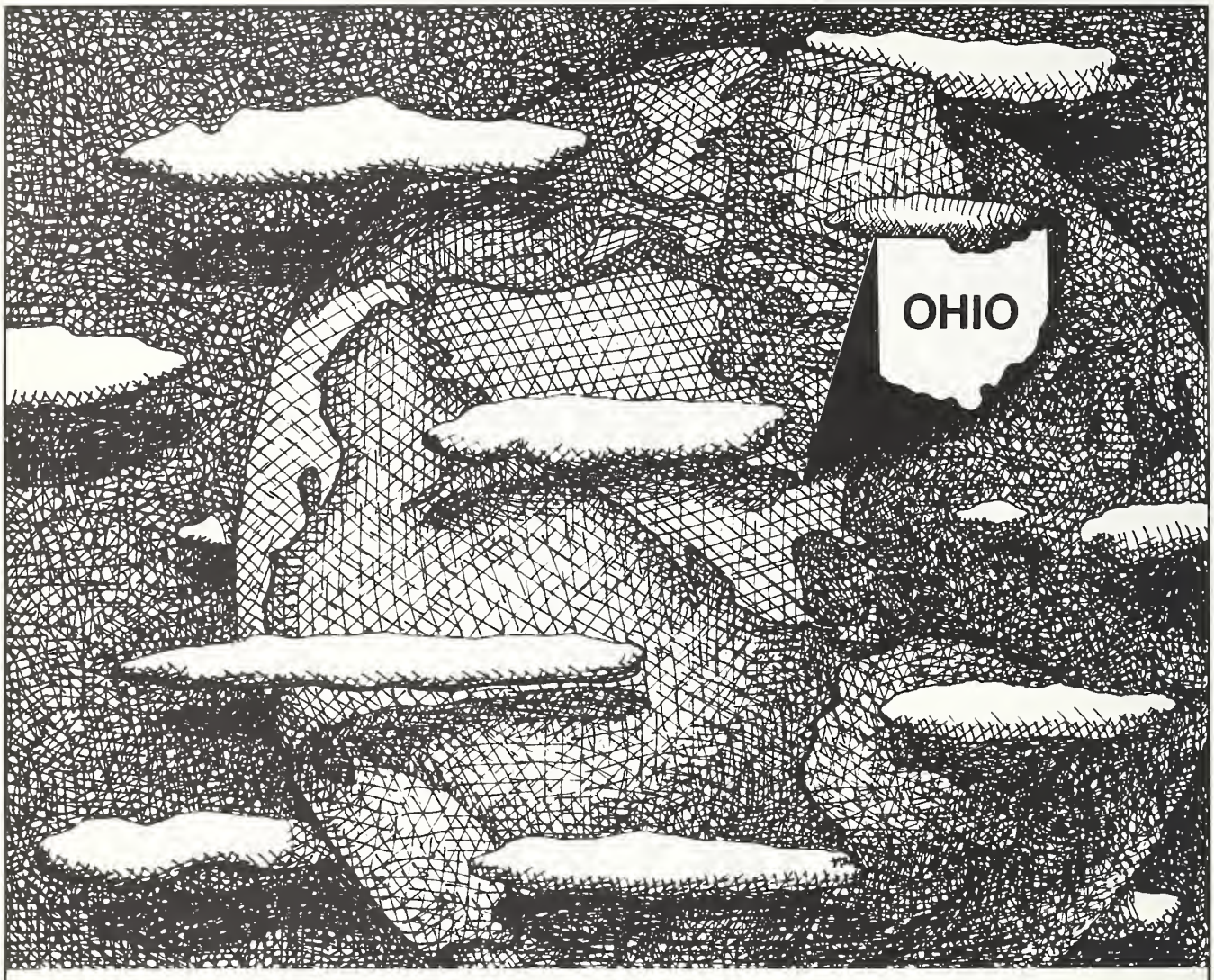


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Medicaid

(Third in a series)

GENERAL ISSUES

Medicaid is a federal- and state-financed program which provides medical, rehabilitative and other health-related services to families with dependent children, the aged, the blind, and the disabled, whose income and resources are insufficient to meet the cost of necessary medical care. In Ohio, the Medicaid program is administered by the Ohio Department of Public Welfare, through both public and private sources. Funds for the program are appropriated to the Department by the legislature each biennium. If the state operates the Medicaid program within the limits set by the federal government, the state is then eligible to receive federal funds on a percentage matching basis.

Ohio's Medicaid program covers those medical services necessary for the diagnosis and/or treatment of a specific problem. (Preventive medicine is **NOT** a recognized service item under Ohio's Medicaid program, except for a specialized health screening program for individuals 21 years of age and under.) Physicians, hospitals, dentists, and other medical providers render or authorize medical services which in their professional judgment, are needed by the individual to correct or improve his or her medical needs. Most procedures are covered by Medicaid — within certain administrative limits; some are covered, if approved in advance by the Department; and a few are not ordinarily reimbursable.

The limitations imposed do not indicate the quantity or type of medical care to be delivered (this decision is the responsibility of the medical provider), but only reflects the Department's necessity to control its fiscal obligations. A medical provider may request payment for a medical service which he believes is essential for a person's well-being, even if that medical service is not ordinarily a reimbursable item.

The following general principles govern the administration of Medicaid, and determine whether a particular medical service is reimbursable:

- The individual must originate all requests for medical services.
- The individual is free to choose the provider of his or her choice.
- The individual may receive those medical services which are necessary to correct or improve the specific medical complaint. "Preventive medicine" is not a covered service item (except for a program known as Early Periodic Screening Diagnosis and Treatment).
- The individual makes no payment (except for liability in the nursing home) for medical services covered by the Medicaid program. This means that a provider accepts the Medicaid payment as payment in full and seeks no additional payment for any unpaid portion of the bill from the patient.
- The individual receives medical services at the same cost as non-Medicaid recipients. This means that Medicaid will not pay for services that are "free" to the general public, or in an amount greater than the customary and prevailing charge to other patients.
- An individual should be provided needed services without regard to his race, color, sex, age, national origin, or economic status.
- An individual has a right to appeal to the Ohio Department of Public Welfare any decision or treatment that adversely affects him.

ENROLLMENT

Physicians who wish to participate in the Ohio Medicaid program may obtain an application/agreement form from:

Ohio Department of Public Welfare
Provider Enrollment Unit
P. O. Box 1461
Columbus, Ohio 43216

A medical provider may request payment for a medical service which he believes is essential for a person's well-being, even if that medical service is not ordinarily a reimbursable item.

The form is designed for direct data input into the State's computers and takes about ten minutes to complete. Notice of approval generally is given in about four weeks.

The notice sent to the enrolled physician (thereafter known as a provider) contains the effective date of enrollment, the Ohio Medicaid seven-digit provider number, the approved categories of service, a list of forms and handbooks which apply to the

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Third-Party Payers Section

(continued)

provider's approved services, and a summary of program procedures. The effective date of enrollment is made retroactive one year prior to the date of application or to the date of licensure, whichever is most recent. This permits billing for services provided prior to actual enrollment — up to the limit of one year after the date of service.

Group numbers are available in the event two or more physicians wish to bill as a single entity or corporation. However, individual members must also have a personal provider number so that he or she can be identified as the attending physician. Should the physician perform a service outside the group, he or she would submit the invoice under his or her own number, and payment would be sent directly to the individual practitioner.

Basically, the agreement contains the requirements mandated by the United States Department of Health and Human Services. In summary, the provider agrees to the following:

1. To keep records necessary to fully describe the services rendered.
2. To furnish the aforementioned records when requested by authorized agencies.
3. Not to exclude from participation, deny benefits, or discriminate against a person on the grounds of race, color, or national origin.
4. To accept as payment in full the amount established by the Department.
5. To inform the Ohio Department of Public Welfare within 30 days of changes in:
   a) ownership
   b) licensure/certification/registration status
   c) specialty
   d) group membership
   e) address
6. To comply with the disclosure requirements specified in Federal Regulation (42 CFR Part 455).
7. To follow the procedures and criteria set forth in the appropriate provider handbooks.

The agreement may be terminated at any time by the provider or the Ohio Department of Public Welfare on a 30-day written notice. Except in cases where the provider is convicted of fraud, suspension, or revocation of licensure, or similar circumstances, the Department must offer an administrative hearing prior to termination of the contract. Conversely, the provider may voluntarily withdraw from the program at any time subsequent to the 30-day notice.

ELIGIBILITY AND MEDICAL IDENTIFICATION CARD

Generally, there are two categories of individuals served under the Medicaid program; recipients of financial assistance under the Aid to Dependent Children program; and those individuals who are age 65 and over, or legally blind, or permanently and totally disabled, who may or may not receive Supplemental Security Income. The determination that an individual or family is or is not eligible for Medicaid is made by the County Welfare Department.

Eligible welfare recipients receive a Medical Assistance Identification Card each month as evidence of eligibility and must be used by members of that family in requesting medical services. This card is valid for a period of one month only, and should be examined on each occasion that a service is requested to ensure that the client currently is eligible. The state cannot pay for services rendered to ineligible persons.

If the client does not have the Medical Assistance Identification Card in his possession, the county welfare office should be contacted to determine eligibility. If the client is not eligible under the Medicaid program, but is eligible under the county General Relief Medical program, any medical bills will be handled through the county welfare office.

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
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Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
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NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
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Third-Party Payers Section

(continued)

some recipients is at varying times during a month (rather than the first of the month as is the rule for most recipients). This variable effective date is typed in by the County Welfare Department, and services rendered prior to that date are not reimbursable, and are the responsibility of the recipient.

The Medical Assistance Identification Card lists those individuals who are eligible for medical assistance. If any third-party insurance resource is known to the Department, that information will be printed directly below the recipient's card number and the provider should then determine the name of the insurance company, type of coverage, and any other pertinent data required from the recipient to file a claim with the proper agency.

Some Medicaid recipients are also covered by Medicare and charges to these recipients must be submitted to the Medicare intermediary. The Medicare intermediary will process the claim and forward coinsurance and/or deductible amounts on approved claims to the Ohio Department of Public Welfare if the claim is processed on an "assigned" basis. Providers are encouraged to accept assignment on Medicare/Medicaid claims since nonassigned claims are not forwarded to the Department.

REIMBURSEMENT

The Department will reimburse the physician for services rendered by considering the following: the physician's usual and customary charge for a specific medical procedure or service; the prevailing charge recognized by Title XVIII (Medicare) for that procedure or service; and the Medicaid maximum, and paying what would amount to the lowest of the three.

When billing for Medicaid services, providers should bill the usual and customary fee which they would charge private-pay patients. This is used to update the Department's usual and customary charge profiles maintained on each Medicaid provider and while Medicaid is aware that often the U/C charge of the physician exceeds the Medicaid maximum, this data is needed to increase reimbursement levels.

The usual and customary charge for a procedure rendered by a provider is calculated on the provider's actual billed charges. The charges for the calendar year immediately preceding the fee screening period (beginning July 1st of each year) are arranged in ascending order. The lowest charge that is high enough to include the median of the arrayed charge data is then designated as the provider's customary charge for that service.

The Medicaid maximum is the highest reimbursement level the Department is able to pay for a specific procedure and remain budgetarily viable. Under state law, the Department may not exceed the budgetary allocation appropriated by the legislature each biennium, and is thus unable to unilaterally raise the reimbursement level of the Medicaid maximum without a corresponding increase in the biennial budget.

BILLING BASICS

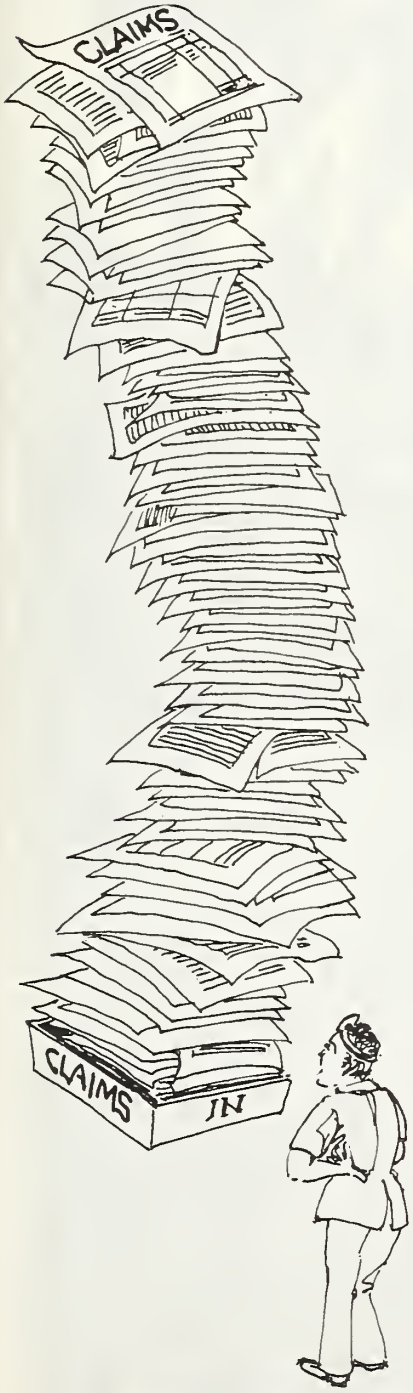
Physicians enrolled in the Ohio Medicaid program submit their claims on an optical scanner document which is read by sophisticated data entry equipment. This equipment can identify a wide range of typewriter or solid character fonts, but because Dot matrix printers are not compatible with the Department's scanner, invoices so prepared cannot be processed.

In addition to scanner input, the Ohio Department of Public Welfare accepts direct entry via magnetic computer tape. A few providers have their own computers, but vast numbers of small offices contract with one of several service bureaus to utilize this data entry method. Direct entry offers the most rapid input

The Medicaid maximum is the highest reimbursement level the Department is able to pay . . . and remain budgetarily viable.

method currently available and accounts for approximately 25 percent of the physician's claims processed by the department.

Regardless of the vehicle used to submit claims, the basic principles of billing apply. In the space here, we will not attempt to offer a complete set of instructions to billing clerks or office staff personnel. The details of proper procedures and program policies must be gleaned from the Ohio Medicaid Handbook, DPW 3331. However, the following summary does provide a basic understanding of the guidelines and will go a long way toward avoiding problems later on.



A) Submission of Claims:

Claims must be filed first with the appropriate insurance carrier, Medicare intermediary, or other agency. The Ohio Medicaid program pays subsequent to all other sources. The maximum limitation for submitting your claim(s) to the Department is one year after the date of service.

B) Information Required:

All claims must include the provider name and number, recipient identification name and number, diagnosis code, procedure code, service date, place of service, units of service, types of service, charge amount, third-party source, and amount and billing date.

C) Diagnosis Codes:

The claim form contains spaces for a primary and secondary diagnosis. Currently, the Department is using codes from the *International Classification of Diseases — Clinical Modification Ninth Edition* (ICD-9-CM) which is available from:

The American Hospital Association
P. O. Box 991
Ann Arbor, Michigan 48106

Although the code is required on all invoices, the descriptive narrative is not.

D) Procedure Codes:

Basically, procedure codes are those found in the *Current Procedural Terminology Fourth Edition (CPT-4).* The Ohio Medicaid program deviates from this reference source somewhat particularly in the visit codes. The Department has adapted a coding system for visits of all kinds (ie, outpatient, inpatient, office, nursing home, etc.). Various injection codes

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SECOND YEAR PRACTITIONERS	Occurrence	$100,000/$300,000 $200,000/$600,000 $1 million excess	70% of the charge for the applicable risk classification
THIRD YEAR PRACTITIONERS	Continuation of coverage at the full charge for the applicable risk classification.		

For more information, contact your local PICO agency, or the PICO home office at 1-800-282-7515, or (614) 864-7100.

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(continued)

are unique to this program and reference to the Ohio Medicaid Handbook, DPW 3331, is essential to avoid procedure code rejections. Current Procedural Terminology books should be obtained from:

The American Medical Association
P.O. Box 821
Monroe, Wisconsin 53566

E) Charges:

Charges submitted on the claim form are to be the same usual and customary amount billed to non-Medicaid patients for similar services. The reimbursement by the Department will be the lowest of the billed charge, the provider's profile, or the maximum allowed amount. Physicians should not bill the amount reimbursed by the Department, since this will affect future profile determinations for a given service.

F) Third-Party Sources:

The Department's file is coded to indicate insurance or other third-party sources of payment. This information is contained in the medical assistance identification card and providers should bill these carriers first and indicate the amount received on the Medicaid invoice form. Claims filed without this information will be returned to the provider for proper follow-up with the carrier.

Once having received the Ohio Medicaid Handbook, DPW 3331, and updates thereto, additional guidance may be obtained through the Office of Provider Assistance. The staff in this office will assist billing personnel with questions ranging from nonpayment problems to billing procedures and policy interpretation. Inquiries should be addressed to:

Ohio Department of Public Welfare
Office of Provider Assistance
P.O. Box 1461
Columbus, Ohio 43216
Telephone: (614)466-7960

The requirements for neatness and the data specificity of the 6190 invoice (which are explained in detail in chapter three of the handbook) encourage accuracy in completing the form. Once the proper coding is mastered, the invoice really is quite simple to use. Whether the form is being sent directly to the Ohio Department of Public Welfare or forwarded to a service bureau for submission via magnetic tape, it should not present any insurmountable problems.

PAYMENTS/REMITTANCE STATEMENTS/ADJUSTMENTS

Barring any unforeseen difficulties or funding problems, the Ohio Department of Public Welfare maintains a 28-day turnaround time for the processing and payment of clean claims. This may vary somewhat from claim to claim, and claims with multiple surgeries and by-report procedures may take a little longer due to the manual review required. Claims which contain errors, are improperly formated, or cannot be read by the Department's scanning equipment, however, are either corrected by the Department before processing (adding days to the average turnaround time), or are returned to the provider for correction.

Barring any unforeseen difficulties . . . the Ohio Department of Public Welfare maintains a 28-day turnaround time for . . . clean claims.

Invoices which pass the Department's edits are forwarded to the Auditor of State for review and approval. Upon receipt of the approved register from the Auditor's office, the remittance statement and warrants (checks) are prepared and mailed to providers. The remittance statement is a line-by-line list of all the claims covered by the enclosed warrant. Although a separate remittance statement is prepared for each service type processed (ie, physicians' services, Medicare cross-over, prescribed drugs, etc.), one warrant is issued to cover the total amount paid.

If charges or individual charges within a claim are reduced or not paid, the reasons for such action will be indicated on the remittance statement. In some cases, they may be reduced because they exceed the Department's allowable or the provider's customary charge for a particular service. In others, denials may result from a noncovered service or an exceeded visit limitation. In any event, the provider is informed of the problem at the time of payment.

Providers who question the amount of payment received from the Department may file for a reconsideration or adjustment via the Claims Adjustment Unit.

Ohio Department of Public Welfare
Claims Adjustment Unit
30 E. Broad St., 37th Floor
Columbus, Ohio 43215

The procedure for filing such a request is contained in the Ohio Medicaid Handbook, DPW 331, Section 107.5. A special review is performed on all adjustment inquiries and appropriate action is taken pending the examiner's and/or medical technical advisor's findings. Documentation supplied with adjustment requests should be as complete as possible to insure a thorough understanding of the situation in question.

Invoices which are rejected in their entirety may be returned to the provider from the claims unit during the processing of the claim. Others will not be rejected until they have cleared all the edits in the Department's system. Such rejections

usually will be listed on the last page(s) of the remittance statement along with the reasons for the rejection. Rejections which are to be corrected and resubmitted should be returned to the Ohio Department of Public Welfare within 90 days. This will avoid problems with the one-year limit to submit a clean claim for reimbursement.

INQUIRY PROCEDURES

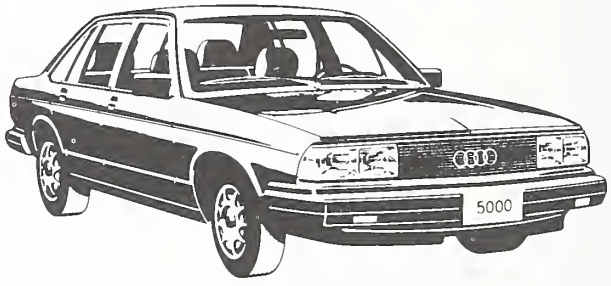
A follow-up inquiry procedure for any claim which has not been paid or rejected within 90 days of the original submission or the resubmission date may be obtained by submitting a cover letter, and legible photocopy of the original invoice to:

Ohio Department of Public Welfare
Office of Provider Assistance
P. O. Box 1461
Columbus, Ohio 43216

Prior to making an inquiry, providers should verify that the claim was not previously paid, disallowed as a noncovered service, rejected for recipient ineligibility, or submitted more than one year after the date of service as specified in the Ohio Medicaid Handbook, DPW 3331. These are the most common problems found on claims received as inquiries. If an error is detected on an invoice, it should be corrected on the copy of the original form being prepared for inquiry. The original billing date must appear on all claims submitted to the Office of Provider Assistance for follow-up, and the cover letter ? must specify the reason for the inquiry, name, address, provider number, and telephone number of the inquirer. Inquiry correspondence and invoice copies should not be included with regular submissions to the claims processing unit. Inquiries are processed in special batches by the provider assistance staff. OSMA

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While the federal government is predicting a physician glut by 1990, no one seems interested in or worried about the current population explosion of licensed lawyers in the nation.

According to Associate U.S. Attorney General, John Shenefield, there are more than 500,000 practicing attorneys in this country, translating to one for every 450 Americans, who are responsible for an estimated 1.25 percent of the country's GNP — more than electric power or steel.

In Washington, he says, there is one lawyer for every 80 residents. — Indiana State Medical Association, **Reports** (September, 1980)

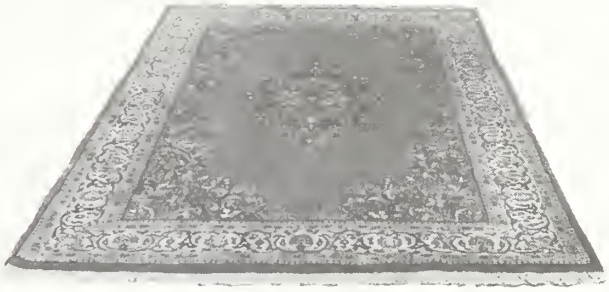
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AMA

The San Francisco Connection

By Oscar Clarke, M.D. and Robert Thomas, M.D.

The American Medical Association (AMA) held its annual interim business meeting in San Francisco this past December. The Ohio delegation was there, and was, in fact, instrumental in formulating AMA policy.

This report covers some of the important issues voted on by the Ohio Delegation at the Interim Business Meeting of the American Medical Association in San Francisco, December 6-10, 1980.

There were 58 reports and over 90 resolutions considered by the House of Delegates. The Ohio Delegation was very active in helping to formulate policy of the AMA.

Oscar Clarke, M.D., is chairman of the Ohio Delegation to the AMA and Robert Thomas, M.D., is OSMA president and co-chairman of the Delegation.

PSRO

A report of the Council on Medical Services provided an update on the PSRO program and recommended that the current AMA policy on PSROs be reaffirmed which calls for "continuation of the PSRO program as a professionally directed effort to ensure that care provided to patients is of high quality, appropriate duration, and is rendered in an appropriate setting at a reasonable cost."

The Ohio Delegation introduced an amendment which asked that the current AMA policy not be reaffirmed and that the Association policy on PSRO be restated as follows:

The current Association Policy shall be to continue professionally directed efforts to ensure that care provided to patients is of high quality, appropriate duration, and is rendered in an appropriate setting at a reasonable cost and to encourage the elimination of all government directed peer review programs including PSRO.

The House of Delegates, by a vote of 104 to 100 adopted the Ohio amendment.

The Ohio Delegation was unanimous in its support of the House action.

UNNECESSARY SERVICES

A resolution which resolved "that it be the policy of the AMA that its members shall not bill or collect



The Ohio Delegation, along with other delegates from around the country, considered 58 reports and over 90 resolutions at the AMA's interim business meeting in San Francisco this past December.

payment for services which have been determined to be unnecessary by a peer review program" was referred to the Board of Trustees for study.

The House supported referral as did the Ohio Delegation.

ETHICAL GUIDELINES FOR PROFESSIONAL ADVERTISING

The House of Delegates adopted this resolution which directs the Board of Trustees to continue to seek court approval of the Association's role in the promulgating and enforcing of reasonable ethical guidelines on physician advertising.

The Ohio Delegation supported adoption of this resolution.

THIRD-PARTY REIMBURSEMENT

The House of Delegates adopted Report G of the Council on Medical Service dealing with third-party reimbursement. Report G responded to Resolution 87 (A-80) seeking to rectify inequities in payment by third parties because of geographical distribution of patients and physicians, and summarized past AMA policy on this problem. The Reference Committee reported that some concern was expressed that the Association was not acting expeditiously enough to correct reimbursement inequities and inadequacies in Medicare. The House's attention was called to a portion of the report which reads as follows:

(b) the development for introduction in the next session of Congress of legislative amendments to the Social Security Act would eliminate provisions calling for the economic index, would require calculation and updating of prevailing charge level on a semi-annual basis, and would allow new physicians in an area be reimbursed immediately at the 75th rather than the 50th percentile; and (c) the reiteration periodically since 1975 of strong Association objections to both the concept and the methodology of the economic index, on each occasion of





Top photo: (l. to r.) John Budd, M.D., Cleveland and Edward G. Kilroy, M.D., Cleveland. Bottom photo: Stewart Dunsker, M.D., Cincinnati, OSMA's President-Elect.



Hart F. Page

Left to right: OSMA President Robert Thomas, M.D., Elyria; Oscar Clarke, M.D., Gallipolis; and Robert N. Smith, M.D., Toledo.

HCFA's publication of the allowed percent of increase in prevailing charges for that year."

The Ohio Delegation was unanimous in support of adoption of CMS Report G.

HEALTH PLANNING

The Reference Committee that considered several resolutions dealing with health planning recommended a substitution resolution which was amended and approved as follows:

"Resolved, That the American Medical Association support immediate cessation of funding for P.L. 93-641 and P.L. 96-79; and be it further

Resolved, That the American Medical Association cause legislation to be introduced in the 97th Congress to repeal P.L. 93-641 and P.L. 96-79, and with the support of the state medical associations seek diligently to pass that legislation; and be it further

Resolved, That, because there are differences in different sections of the country, wherever state and regional attitudes and directives pose specific problems in regard to planning, the medical profession should accept responsibility and assume a position of leadership; and be it further

Resolved, That the American Medical Association develop principles for a program of voluntary, locally based health planning designed to address local needs with local resources as an alternative to P.L. 93-641 and P.L. 96-79.

The Ohio Delegation voted unanimously in support for adoption of this amended substitute resolution.



John Budd, M.D., Cleveland







Above: Oscar Clark, M.D., Gallipolis, congratulated after a presentation
Left: Paul Metzger, M.D., Columbus
Right: William Dorner, M.D., Akron (all photos by Richard Ayish, unless otherwise noted)

NATIONAL HEALTH SERVICE CORPS AND UNDERSERVED AREAS

A resolution which called on the AMA to seek amendment to P.L. 91-623 to require that findings of local medical societies and practitioners be included in the decision process in the designation of areas as "underserved" for the purpose of placement of National Health Service Corps physicians was referred to the Board of Trustees. The Reference Committee recommended referral because the Council on Legislation is conducting a major review of the total Corps program with a view toward making recommendations to the Board of Trustees on all aspects of the Corps program.

The Ohio Delegation voted in support of referral.

FTC AND THE LEARNED PROFESSIONS

The House of Delegates referred to the Board of Trustees two resolutions which called on the AMA to prepare legislation which exempt the medical profession from the jurisdiction of the Federal Trade Commission and which would prohibit the FTC from preempting state laws. In recommending referral, the Reference Committee stated its belief that the

Board of Trustees should retain flexibility, particularly in light of pending litigation, to pursue this matter in the manner it deems most appropriate. The Board informed the Committee of its continued support for the sense of two resolutions.

The Ohio Delegation voted in support of referral.

THE ESSENTIALS OF ACCREDITED RESIDENCIES IN GRADUATE MEDICAL EDUCATION

Two separate reports were presented on the Essentials of Accredited Residencies in Graduate Medical Education. The Council on Medical Education report transmitted a revision of the essentials recommended by the Liaison Committee on Graduate Medical Education for adoption by its sponsoring professional organizations.

The other report issued by the Board of Trustees outlines the complexity and importance of the issues and differing points of view inherent in the essentials and recommends that the revision prepared by the Liaison Committee on Graduate Medical Education be referred to the Board of Trustees to continue discussions with other sponsoring organizations of the LCGME.

The House adopted the report of the Board of Trustees in lieu of the report of the Council on Medical Education and the Ohio Delegation supported this action. A progress report is to be made to the House at the 1981 Annual Meeting.

MATERNAL SERUM ALPHA-FETAPROTEIN SCREENING

The Reference Committee hearing this subject considered a report of the Council on Scientific Affairs and a resolution. The report of the CSA contained a discussion of maternal serum alpha-fetaprotein screening, recommending that its use not be encouraged as a screening technique for all pregnant women, and encouraged the development of a carefully planned educational program on such testing and prenatal counseling for physicians and patients. The resolution opposed the federal proposals to regulate alpha-fetaprotein diagnostic kits.

The House adopted the report of the Council on Scientific Affairs and a substitute resolution as follows:

Resolved, That the American Medical Association actively oppose the Department of Health and Human Services current proposals to regulate the sale and use of AFP (alpha-fetaprotein) diagnostic kits; and be it further

Resolved, That the ligitimate concern for the safe and effective use of AFP in the complicated testing chain required for the identification of fetal neural tube defect be addressed as outlined in the Council on Scientific Affairs Report I, I-80; and be it further

Resolved, That the AMA reaffirm its objection to the use of the Medical Device Amendments Act of 1976 as a means of controlling the practice of medicine.

The Ohio Delegation supported these actions.

AMERICAN MEDICAL WOMEN'S ASSOCIATION REPRESENTATION IN AMA HOUSE OF DELEGATES

A resolution seeking a seat in the House of Delegates for the American Medical Women's Association (AMWA) was referred to the Board of Trustees. The Reference Committee, in recommending referral, pointed out that while the AMWA does not meet the established criteria for representation in the House of Delegates, the Council on Long Range Planning and Development is currently considering the representational make-up of the House and may suggest changes in the future. Further, the Committee felt that the role of women in the AMA should be considered by the Council in its deliberations.

The Ohio Delegation voted in support of referral.

There are many excellent reports prepared by the AMA Board of Trustees and the several Councils which are presented to the House for its consideration. These reports which contain a wealth of information are well prepared and researched. A listing, by title, of some of the reports follows. If you would like a copy of any of these reports, please contact the OSMA office.

1. AMA Budget - Fiscal 1981
2. Confidentiality of Occupational Medical Records
3. Surgeon General's Report on Health Promotion and Disease Prevention
4. Physician Suicide
5. Evaluation of AMA Policy on Physician Assistants
6. Report of Women Physicians in Organized Medicine
7. Survey of Current Status of Continuing Medical Education
8. Status Report on HMOs
9. Hospice Programs
10. Medicare Handling of Bad Debts
11. Use of Phrase "Usual, Customary and Reasonable" by Health Insurance Carriers
12. Medicare Reimbursement Policy
13. Third-Party Reimbursement
14. Health Care Technology Assessment - 1980
15. Importance of Diagnostic Computerized Tomographic Scanning
16. Carcinogen Regulation
17. Marijuana in the '80s
18. Indications and Contraindications for Exercise Testing
19. Organ Donation and Transplantation
20. The Nutritive Quality of Processed Foods: General Policies for Nutrient Additions
21. Alcoholism as a Disability
22. Maternal Serum Alpha-Fetaprotein Screening OSMA

Beginning in March, the Ohio State Medical Journal will publish the reports listed above on a monthly basis.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Furniture & Equipment	$ 5,000.00	0	0	$ 1,500.00
Term Debt: Current	3,384.00	2,400.00	1,440.00	1,056.00
Journal: Publication Cost	0	0	0	0
Salaries & Ins. Benefits	93,450.72	100,186.12	52,077.56	49,102.56
Staff Development	80,000.00	0	0	0
Staff Expense	12,000.00	7,350.00	3,553.00	9,200.00
President Expense	12,000.00	0	0	0
President-Elect Expense	6,000.00	0	0	0
Officer Honorariums	19,000.00	0	0	0
Council Expense	75,000.00	0	0	0
AMA Del/Alt Expense	0	0	0	0
Committees	7,300.00	15,150.00	17,009.00	0
Annual Meeting	0	121,650.00	0	0
Bad Debt Expense	0	0	0	0
Building Expense	7,896.00	5,600.00	3,360.00	2,464.00
Car Lease	12,600.00	0	2,600.00	7,200.00
Contributions	0	0	0	0
Councilor Dist. Conference	10,000.00	0	0	0
Data Processing	0	0	0	0
Depreciation Expense	4,300.00	2,960.00	1,360.00	1,080.00
Equipment Lease & Supply	2,303.00	5,734.00	3,384.00	2,303.00
Equipment Maint. Agreement	245.00	610.00	360.00	245.00
Emergency Fund	4,000.00	2,500.00	1,000.00	600.00
Insurance and Bonding	23,200.00	800.00	1,100.00	1,100.00
Interest Expense	1,974.00	1,400.00	840.00	616.00
Legal Expense	75,000.00	0	0	0
Library	500.00	200.00	250.00	400.00
Meeting Expense	0	0	0	4,500.00
Misc. Supplies	600.00	1,000.00	400.00	500.00
OSMAgram	0	0	0	0
Pension Expense	7,000.00	7,700.00	3,500.00	3,500.00
Postage	2,000.00	4,500.00	3,500.00	1,200.00
Printing & Office Supply	4,000.00	6,000.00	700.00	1,000.00
Prof. Relations Activity	945.00	1,600.00	1,450.00	600.00
Public Relations Expense	0	0	0	0
Taxes: Payroll	3,600.00	7,200.00	3,300.00	3,400.00
Taxes: State and Local	0	0	0	0
Telephone and Telegraph	6,715.00	4,345.00	2,765.00	2,765.00
TOTAL 1981 BUDGET	$480,012.72	$298,885.12	$103,948.56	$ 94,331.56

1981 Budget: Department Analysis

05 Fiscal Mbrshp.	06 Govt. Rel.	07 Commun.	08 Org. Serv.	09 State-Fedl. Leg.	10 Rental Area	1981 Budget Totals
$ 53,100.00	0	$ 6,000.00	$ 2,510.00	$ 1,800.00	0	$ 69,910.00
3,768.00	1,440.00	2,664.00	2,568.00	2,712.00	$ 2,568.00	24,000.00
0	0	175,000.00	0	0	0	175,000.00
188,215.16	99,478.84	111,617.12	91,374.56	166,993.12	0	952,495.76
0	0	0	0	0	0	80,000.00
10,000.00	13,600.00	10,000.00	7,000.00	43,700.00	0	116,403.00
0	0	0	0	0	0	12,000.00
0	0	0	0	0	0	6,000.00
0	0	0	0	0	0	19,000.00
0	0	0	0	0	0	75,000.00
0	0	0	79,218.00	0	0	79,218.00
20,000.00	16,570.00	800.00	800.00	5,000.00	0	82,629.00
0	0	0	0	0	0	121,650.00
0	0	500.00	0	0	0	500.00
8,792.00	3,360.00	6,216.00	5,992.00	6,328.00	5,992.00	56,000.00
2,600.00	5,000.00	0	2,600.00	5,200.00	0	37,800.00
0	0	0	0	0	0	0
0	0	0	0	0	0	10,000.00
65,000.00	0	0	0	0	0	65,000.00
27,580.00	1,360.00	3,620.00	2,580.00	3,620.00	1,540.00	50,000.00
10,340.00	3,431.00	6,862.00	4,606.00	8,037.00	0	47,000.00
1,100.00	365.00	730.00	490.00	855.00	0	5,000.00
3,000.00	0	2,000.00	500.00	2,000.00	0	15,600.00
1,100.00	1,400.00	800.00	1,100.00	1,400.00	0	32,000.00
2,198.00	840.00	1,554.00	1,498.00	1,582.00	1,498.00	14,000.00
0	0	0	0	0	0	75,000.00
500.00	0	2,000.00	100.00	1,500.00	0	5,450.00
0	0	0	0	0	0	4,500.00
2,000.00	650.00	1,300.00	800.00	1,250.00	0	8,500.00
0	0	25,000.00	0	0	0	25,000.00
14,000.00	7,000.00	8,400.00	6,300.00	12,600.00	0	70,000.00
10,000.00	0	4,000.00	1,900.00	4,000.00	0	31,100.00
10,000.00	0	15,000.00	1,600.00	16,000.00	0	54,300.00
600.00	5,600.00	600.00	600.00	600.00	0	12,595.00
0	0	50,000.00	0	0	0	50,000.00
14,100.00	6,100.00	8,000.00	5,900.00	12,000.00	0	63,600.00
0	0	0	0	0	0	0
5,135.00	3,555.00	4,740.00	3,555.00	5,925.00	0	39,500.00
$453,128.16	$169,749.84	$447,403.12	$223,591.56	$303,102.12	$ 11,598.00	$2,585,750.76



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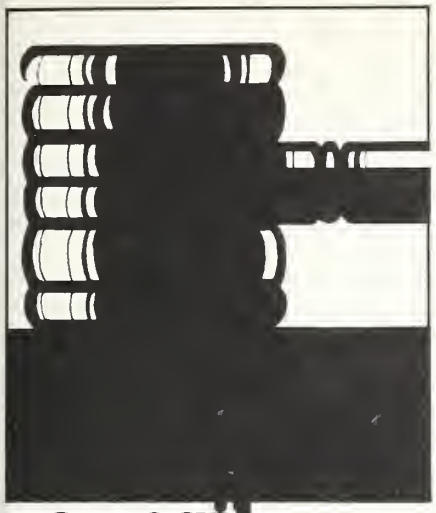
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council proceedings

PROCEEDINGS OF THE COUNCIL

December 13, 1980

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, December 13, 1980, at the OSMA Headquarters Office, 600 South High Street, Columbus, Ohio.

Those present were: Robert G. Thomas, M.D., Elyria; Stewart B. Dunsker, M.D., Cincinnati; Thomas W. Morgan, M.D., Gallipolis; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; William Dorner, M.D., Akron; W. J. Lewis, M.D., Dayton; James E. Pohlman, Esq., Columbus; and Oscar W. Clarke, M.D., Gallipolis.

Those present from the OSMA staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Robert E. Holcomb; Gail E. Dodson; Rebecca J. Doll; David C. Torrens; Carol W. Mullinax; David W. Pennington; Eric Burkland; Michael Bateson; and Jennifer O'Brien.

ADMINISTRATION DEPARTMENT

The minutes of the November 15, 1980 meeting of the Council were approved.

Ad Hoc Committee on Association Structure — Dr. Dunsker presented the minutes of the Ad Hoc Committee on Association Structure which met December 12, 1980.

He announced the assignment of Councilors to be responsible for reviewing the progress to Association goals:

"1. Membership — Dr. Morgan.

2. Legislative — Dr. Morgan.

3. Increasing new operating revenues — Dr. Barr.

4. OSMA and member image and improving communications — Dr. Abromowitz.

5. Increasing operating efficiency — Dr. Dunsker.

6. Third-party reimbursement and cost of health care delivery — Dr. Abromowitz.

7. Physician distribution — Dr. Reamy."

A committee to review and evaluate possibilities for increasing nondues revenue was recommended, and was approved. The committee is Dr. Ford, Chairman; Dr. Barr; and Dr. Pfahl.

The minutes as a whole were accepted.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Dr. Barr presented the report of the Treasurer.

Dr. Ford presented the minutes of the December 12, 1980 meeting of the Committee on Auditing and Appropriations.

The December 9, 1980 report of the Ad Hoc Committee to Consider Officer Reimbursement Expense was accepted for information.

The purchase of 622 South High Street property was approved.

The report of the OSMA Pension Committee was approved as recommended by the Committee on Auditing and Appropriations.

The Council approved conversion of the present board room to office space and the construction of a new board room in the lower lounge meeting space.

A motion to reimburse the members of the Council who are neither delegates nor alternates to the AMA on the same basis as the official delegates and alternates was defeated.

The Council expense line item of $75,000 was passed with three dissenting votes (Drs. Abromowitz, Pfahl, and Yut).

The Budget as amended was adopted (see attachment).

Ad Hoc Committee on Membership — Dr. Morgan presented a progress report of the Ad Hoc Committee on Membership.

Membership statistics were reviewed by Ms. Wisse, indicating continued gains over the previous year.

DEPARTMENT OF EDUCATION AND MEETING MANAGEMENT

The Council studied statistics resulting from the evaluation questionnaires submitted by those who attended the November 16, 1980 OSMA/AMA Update Meeting.

The statistics and the summary of results were referred to the Ad Hoc Task Force to Study Leadership Conferences, Interim Sessions, and District Conferences.

DEPARTMENT OF GOVERNMENT RELATIONS

Mr. Gillen presented a communication dated December 11, 1980, from Kenneth B. Creasy, Director of the Ohio Department of Welfare.

Also discussed was a letter dated December 8, 1980, from Mr. Creasy to the members of the Ohio General Assembly, which analyzed "The Financial Crisis in Public Welfare and Effects of an Additional Ten Percent Cut."

Dr. Morgan suggested the proposal of a federal tax credit program for providers as a possible help in solving the problem.

Dr. Ford discussed a possible proposal for income tax deduction for providers on a state level.

The matter was referred to the Committee on Government Medical Care Programs for intensive study and the Council **approved** a statement for release to the public and to the profession.

Mr. Pennington discussed the Certificate of Need Board activities and Certificate of Need regulations.

In addition, health planning activities were reviewed.

Blue Cross "Incentive/Disincentive Program" — Mr. Gillen reviewed the incentive/disincentive programs of Blue Cross of Southwestern Ohio.

A letter from A. Robert Davies, M.D., vice president of the Miami County Medical Society, regarding the program was received by the Council and was discussed.

The matter was referred to Legal Counsel for investigation and report.

DEPARTMENT OF ORGANIZATION SERVICES

Dr. Lewis reviewed the San Francisco meeting of the American Medical Association.

He indicated that there was considerable discussion by the Board of Trustees of the revision of the "Essentials of an Approved Residency."

He indicated that the Board supported the opinion of the student and resident sections of the AMA that the current revision is unsatisfactory.

The Council commended the AMA Board of Trustees for their action on this matter.

Dr. Lewis reported the following with regard to a restatement of AMA policy on Professional Standards Review Organizations:

> "The current Association policy shall be to continue professionally directed efforts to ensure that care provided to patients is of high quality, appropriate duration, and is rendered in an appropriate setting at a reasonable cost and to encourage the elimination of all government directed peer review programs including PSRO."

Mr. Campbell presented the following recommendations from Ohio's AMA Delegation with regard to candidates for AMA offices, and they were duly **approved** by the Council:

W. Jack Lewis, M.D., Dayton, **for Trustee** (reelection)

Lawrence J. McCormack, M.D., Cleveland, **nomination for Council on Medical Service.**

John E. Albers, M.D., Cincinnati, **nomination for Council on Medical Education.**

Carl E. Spragg, M.D., New Concord, **Accreditation Council for Continuing Medical Education.**



John Beljan, M.D., Dayton, **nomination for reelection to the Council on Scientific Affairs.**

PICO

Mr. Campbell presented a report on Physicians Insurance Company of Ohio and its subsidiaries.

DEPARTMENT OF HEALTH EDUCATION

Committee on Mental Health — The Council discussed the subject "Parity for Psychiatric Insurance Benefits."

The Council voted to support the Ohio Psychiatric Association proposal on this subject, in principle, with the reservation that the fiscal input of such coverage be clearly identified in the marketing of such coverage plans.

DEPARTMENT OF STATE AND FEDERAL LEGISLATION

Mr. Mulgrew reported on State Budget Deficit Problems; the passage of a new law to permit recovery of legal expenses of individuals and associations who are sued by the Federal government and 96-499, Budget Reconciliation Act. A complete analysis of 96-499 will be in the OSMA February's Legislative Update.

State Legislation — Mr. Burkland discussed new Republican committee chairmen in the State Senate and leadership changes in the Senate and House.

Prisons and Jails — Mr. Bateson discussed problems of treatment of state prisoners in private institutions and reported on developments in the operation of the jail project.

COMMUNICATIONS DEPARTMENT

Ms. Doll and Ms. Mullinax reported on OSMA publications and development plans for 1981.

Ms. Doll announced that she is meeting with AMA marketing staff with regard to marketing of physicians' services.

FIELD SERVICE DEPARTMENT

Mr. Holcomb reported on field service activity.

COUNCILOR REPORTS

The Councilors reported on the activities in their districts.

A letter dated December 8, from Dr. N. M. Camardese, Norwalk, requesting financial assistance in pursuing litigation proposed by him, was studied by the Council.

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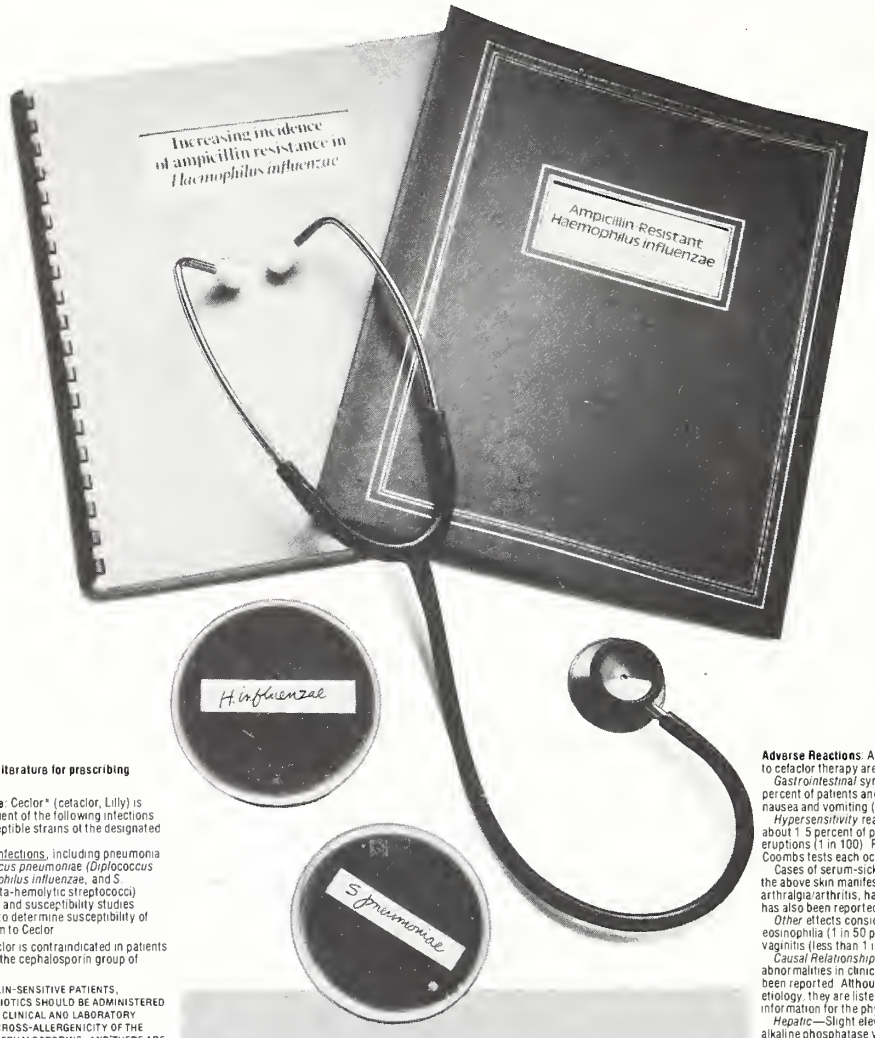
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Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file: Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

100061

It was the Council's decision that the litigation proposed does not meet the criteria established by the Council on September 8-9, 1979, and on the advice of Legal Counsel, and in accordance with the established criteria, the Council voted not to participate in litigation proposed by Dr. Camardese.

LEGAL COUNSEL REPORT

Mr. Pohlman presented the report of the Legal Counsel.

There being no further business, the meeting was adjourned.

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CONTINUING EDUCATION PROGRAMS

February

THIRTEENTH ANNUAL INFECTIOUS DISEASE CONFERENCE: February 26; Kresge Auditorium, Cincinnati University College of Medicine; sponsor: Infectious Disease Division Department of Internal Medicine, University of Cincinnati College of Medicine; cosponsor: Sexually Transmitted Disease Training Center; 6 credit hours; fee: $20, $10 Residents and other Health Professionals; contact: Michael D. Kerr, Sexually Transmitted Disease Training Center, 3101 Burnet Ave., Cincinnati 45229, phone: 513/352-3152.

March

INTER-CONTINENTAL CONFERENCE ON COMPARATIVE MEDICINE: March 4-14; Cairo, Egypt; sponsor: Ohio Academy of Family Physicians; 22 credit hours; contact: Mrs. Florence I. Landis, 4075 N. High St., Columbus 43214, phone: 614/267-7867.

UPDATE ON COMMON CANCERS: LUNG-BREAST-COLON: March 11; Greene Memorial Hospital, Xenia; sponsor: Greene Memorial Hospital; cosponsor: American Cancer Society; 7 credit hours; fee: $25; contact: Arlene Polster, Wright State University School of Medicine, Box 927, Dayton 45401, phone: 513/372-7140.

CURRENT MANAGEMENT OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE: March 25; Imperial House South, West Carrollton; sponsor: Department of Medicine, Wright State University School of Medicine; 6 credit hours; fee: $45 Wright State Faculty, $55 others; contact: Arlene Polster, Wright State University School of Medicine, Box 927, Dayton 45401, phone: 513/372-7140.

BREAST FEEDING: A GUIDE FOR THE PROFESSIONAL: March 25; Good Samaritan Hospital Auditorium, 3217 Clifton Avenue, Cincinnati; sponsor: Good Samaritan Hospital; 6 credit hours; fee: $20; contact: Elizabeth Wade, M.D., Good Samaritan Hospital, 3217 Clifton Ave., Cincinnati 45220, phone: 513/872-2746.

GERIATRIC MEDICINE AND THE FAMILY PHYSICIANS - OUR ROLE TODAY AND TOMORROW: March 29; Rodeway Inn, 900 E. Dublin-Granville Road, Columbus; sponsor: Ohio Academy of Family Physicians; 6 credit hours; fee: $50 AAFP Members, $25 residents and students; contact: Mrs. Florence I. Landis, 4075 N. High Street, Columbus 43214, phone: 614/267-7867.

April

RADIONUCLIDE/HEART FAILURE—HOW TO IN 1981: April 3-4; Harley Hotel, 1000 East Dublin-Granville Road, Columbus; sponsor: Central Ohio Heart Chapter; 7.5 credit hours; fee: $75; contact: Ed Jachym, Program Director, Central Ohio Heart Chapter, 200 East Rich Street, Columbus 43216, phone: 614/228-6327.

NUTRITION, THE CORE OF GOOD HEALTH: April 5; Sheraton-Columbus Hotel, Columbus; sponsor: Ohio Academy of Family Physicians; 7 credit hours; no fee; contact: Mrs. Florence Landis, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

MANAGEMENT OF THE DIZZY PATIENT: April; 8; Daytonian Hotel, Dayton; sponsor: Wright State University School of Medicine, Department of Otolaryngology; 7 credit hours; fee: $50 Wright State Faculty, $65 others; contact: Arlene Polster, Box 927, Dayton 45401, phone: 513/372-7140.

SPORTS MEDICINE SYMPOSIUM: April 23-24; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $100, $50 for residents; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

DIAGNOSTIC IMMUNOLOGY: April 27-28; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $120, $60 residents; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444- 5696.

MEDICAL PROGRESS FOR THE FAMILY PHYSICIAN: April 29-30; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 14 credit hours; fee: $100, $50 residents; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

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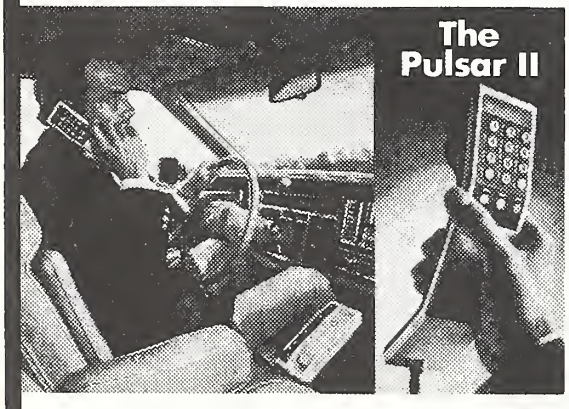
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Obituaries



Richard L. Fulton, M.D.

RICHARD L. FULTON, M.D.

Richard L. Fulton, M.D., past president of the Ohio State Medical Association (OSMA), died Saturday, December 20, 1980, in Columbus, Ohio after an extended illness.

Dr. Fulton was in the practice of internal medicine at the Columbus Medical Center until his illness. He was a diplomate of the American Board of Internal Medicine as well as a fellow of the American College of Physicians.

A graduate of Wittenberg University and the Ohio State University College of Medicine, Dr. Fulton was an active participant in medical affairs. Besides his term as OSMA president (1970-1971), he also served as president of the Columbus Academy of Medicine, the Metropolitan Health Council and the Central Ohio Diabetes Association.

An OSMA alternate delegate to the American Medical Association for nine years, Dr. Fulton served as delegate from May 1980, until his death. He was also an active member of various committees at both the Columbus Academy and the OSMA.

Dr. Fulton donated as much time to the Columbus community as he did to the medical community. A former medical advisor to the Columbus Chamber of Commerce, Dr. Fulton was active in United Way, the United Community Council, Peer Review, Metropolitan Health Council and Kiwanis Club. In 1972, he was named by the Columbus Citizen-Journal as one of ten outstanding men of the year for his efforts in the "Sabin on Sunday" polio inoculation program.

Dr. Fulton is survived by his wife Joan and one son.

EDWARD B. GALL, M.D., Dayton; Ohio State University College of Medicine, 1933; age 75; died November 9; member OSMA and AMA.

JAMES R. GILLIS, M.D., Youngstown; University of Michigan Medical School, Ann Arbor, Michigan, 1946; age 58; died November 7; member OSMA and AMA.

DONALD M. GLOVER, M.D., Cleveland; Harvard Medical School, Boston, 1920; age 85; died December 2; member OSMA and AMA.

JOHN E. HASTINGS, M.D., Columbus; University of Iowa College of Medicine, Iowa City, 1951; age 55; died November 26; member OSMA and AMA.

KENNETH C. JEE, M.D., Winchester; West China Union University College of Medicine and Dentistry, China, 1948; age 59; died November 19; member OSMA and AMA.

ROSCOE D. LEAS, M.D., Chagrin Falls; Case Western Reserve University School of Medicine, Cleveland, 1922; age 87; died November 19; member OSMA and AMA.

SAMUEL OKRENT, M.D., Cincinnati; University of Cincinnati College of Medicine, 1912; age 92; died July 3; member OSMA and AMA.

ANTHONY J. PERKO, M.D., Cleveland; St. Louis University School of Medicine, St. Louis, 1925; age 80; died November 12; member OSMA and AMA.

ROBERT F. SCHULTZ, M.D., Winter Haven, Florida; University of Michigan Medical School, Ann Arbor, 1925; age 91; died November 24; member OSMA and AMA.

LOREN SIEFFERMAN, M.D., Harrison; University of Cincinnati College of Medicine, 1931; age 76; died November 21; member OSMA and AMA.

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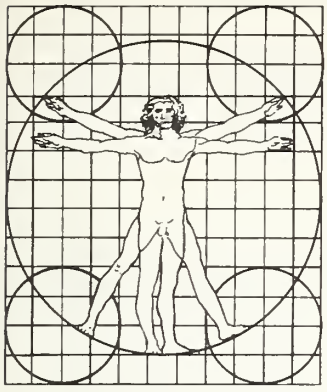
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Stephen G. Moon, M.S.
Wayne A. Oliver, Ph.D.

Erectile impotence has been a problem for the patient and a frustration for the physician since the beginning of medical history. The inflatable penile prosthesis rapidly is becoming the standard for treatment of organic erectile impotence. A technic is described and illustrated for implantation through a single midline scrotal incision. Intra-abdominal reservoir placement is possible through this incision. The technic shortens operative time, hospital stay, and minimizes postoperative patient discomfort. Twenty-four patients have been managed in this way, and the postoperative course of 14 patients is longer than 12 months. The results as judged by both patient and sexual partner have been excellent to date.

THE PROBLEM OF IMPOTENCE is cited in the Old Testament. [1] In the medical literature, a theory of the physiology of erection appeared as early as 1573.[2] The first report of implantation to treat the problem was in 1936, at which time a section of rib cartilage was used.[2] Implantation as a reliably successful method of treatment had to await the development of Silastic.®

Scott and Associates reported successful implantation of the inflatable penile prosthesis in 1973.[3] Improvements in design during the ensuing seven years have made it a reliable and viable method of treatment. Surgical management of organic erectile impotence has come of age.

Patient Selection

All implant candidates were diagnosed as having organic impotence. They were evaluated with history, physical examination, psychological testing, and interview. Lower extremity electromyography, glucose tolerance testing, nocturnal penile tumescence studies, and penile blood pressures were used in selected cases. The etiologies included diabetes mellitus, radical cancer surgery of bladder, prostate, or rectum, atherosclerotic obstruction of major pelvic arteries, pelvic trauma, Peyronie's disease, and spinal cord injury.

Method

The Scott inflatable penile prosthesis consists of the following components: reservoir, paired penile cylinders, and pump (Fig. 1). The pump is comprised of an inflate/deflate mechanism. Scott has devised a technic of implantation that is illustrated here.

A single midline incision is made in the scrotum (Fig. 2a). The urethra and corpora cavernosa are exposed with ease (Fig. 2b). A Scott ring retractor is used to allow precise tissue control. An incision is made in each corporal body and a space is developed by dilatation that extends from the subglandular limit distally to the ischial tuberosity proximally (Fig. 3a).

The appropriate cylinder length is determined with the inserter developed by Furlow[4] (Fig. 3b), and a cylinder is positioned in each corporal body using this instrument (Fig. 4). The incisions in the corporal bodies are then closed, and a subdartos scrotal pouch for the pump is developed by shifting the mobile scrotal skin. The spermatic cord is retracted laterally to allow palpation of the inguinal canal just proximal to the pubic tubercle. The transversalis fascia is punctured at this point (Fig. 5).

The extraperitoneal space is developed by blunt dissection and can be visualized using a nasal speculum. The reservoir subsequently is placed in the extraperitoneal space medial to the epigastric vessels and beside the bladder (Fig. 6). The reservoir is filled and the inserter removed; this reservoir is now located intra-abdominally and extraperitoneally (Fig. 7). It seats in the transversalis fascia defect preventing herniation (Fig. 8a).

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Dr. Oliver, Columbus, Clinical Psychologist, Riverside Methodist Hospital, Columbus, Ohio.
Submitted August 7, 1980.

The pump is placed in the subdartos scrotal pocket so that the deflate valve is lateral. The tubing to the right penile cylinder is passed through the scrotal septum to prevent torsion of the pump (Fig. 8b). Tubing then is cut to the appropriate length, and the connections are made (Fig. 8c). The scrotal incision is closed with nonabsorbable suture.

Postoperative patient and partner satisfaction was studied by inquiries made during outpatient follow-up by the attending surgeon.

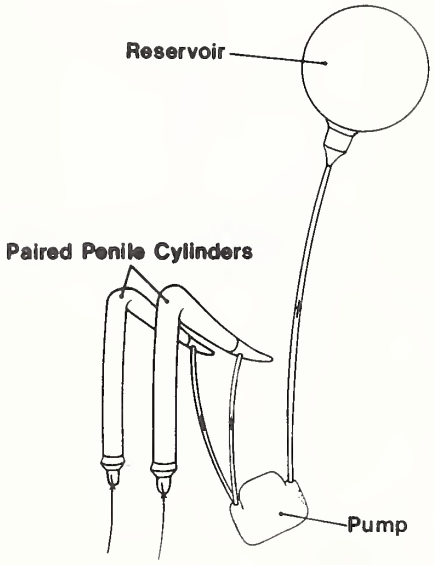
Results

Twenty-four patients have been implanted. To date the longest postoperative is 25 months and the shortest one month. Fourteen patients have been followed 12 months or longer and ten patients less than one year. When the scrotal approach is utilized, the postoperative stay is four days or less. Patients are seen in the office on the average of one visit per week during the first four postoperative weeks. Instruction in the inflation and deflation of the device is given at the beginning of the third week.

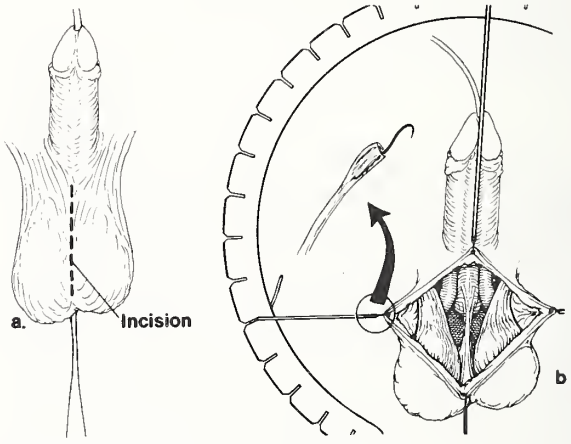
Significant discomfort has subsided by the fourth week, and most patients report successful attempts at intercourse by the sixth week. All patients report a sexual life style with which they are satisfied, have an adequately functioning prosthesis, and enjoy coitus.

Comment

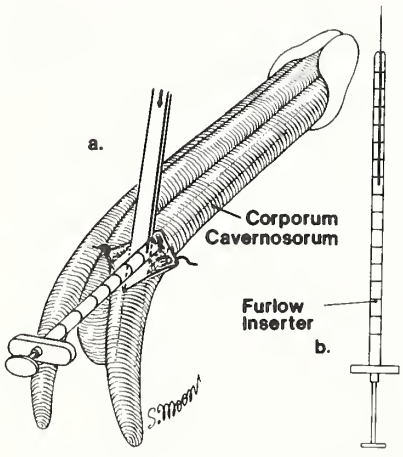
The inflatable penile prosthesis produces a physiologiclike erection which is a practical solution for organic impotence. The technic of scrotal implantation devised by Brantley Scott and illustrated in this paper has simplified the operative procedure, shortened hospital stay, and lessened patient discomfort. Outcomes to date have been excellent and implantation within the context of an ambulatory care facility, with careful preoperative selection and postoperative monitoring, seems feasible.



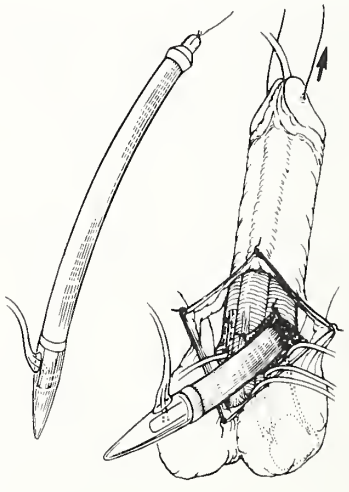
(Fig. 1) The Device Consists of These Components: Reservoir, Paired Penile Cylinders and Pump



(Fig. 2a) Location of the Midline Scrotal Incision.
(Fig. 2b) The Urethra and Corpora Cavernosa are Exposed with the Use of the Scott Ring Retractor.

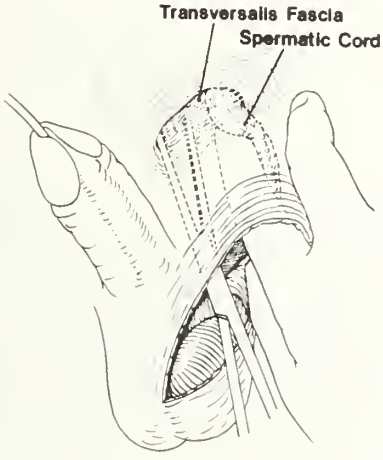


(Fig. 3a) The Corporal Body is Opened and Dilated from the Subglandular Limit Distally to the Ischial Tuberosity Proximally.
(Fig. 3b) The Furlow Cylinder Inserter.

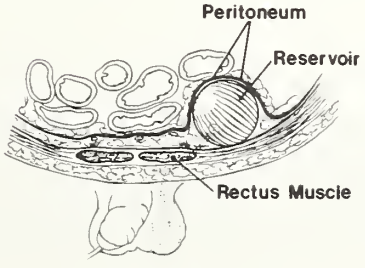


(Fig. 4) The Penile Cylinders Insert into the Corporal Body; a Subdartos Pocket has been Developed for the Pump.

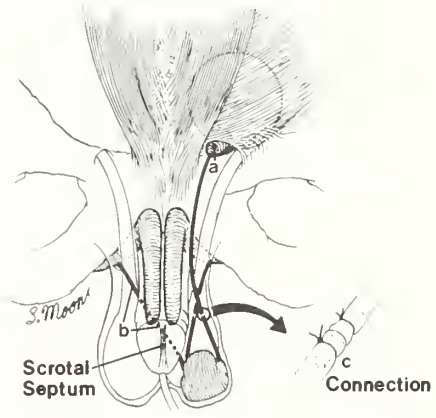
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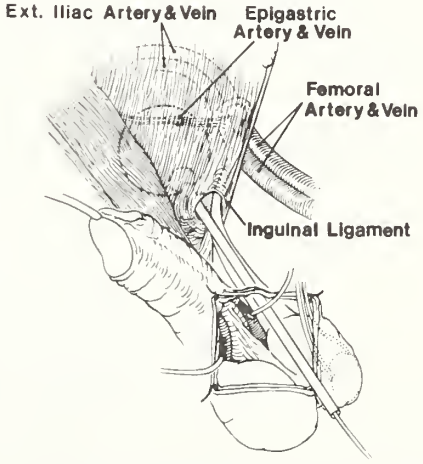
(Fig. 5) The Spermatic Cord is Retracted Laterally and the Endopelvic Fascia is punctured Just Proximal to the Pubic Tubercle.



(Fig. 7) The Reservoir is Located in the Intra-Abdominal Extraperitoneal Space.



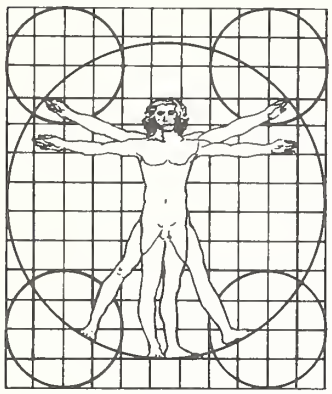
(Fig. 6) The Reservoir is Placed in the Intra-Abdominal Extraperitoneal Space with the Scott Reservoir Inserter.



(Fig. 8a) The Reservoir Tip Seats in the Endopelvic Fascia Defect.

(Fig. 8b) The Tubing from the Pump to the Right Penile Cylinder Passes Through the Scrota Septum to Prevent Torsion.

(Fig. 8c) The Technique for Tubing Connection is Illustrated.



CLINICAL & SCIENTIFIC

THE NEGATIVE PLACEBO RESPONSE

William H. Havener, M.D.

The negative placebo response can harm physicians as well as patients. This is a discussion of one of the most toxic and destructive elements within the practice of medicine.

NO EVALUATION OF THE TOXIC and undesirable effects of drugs can be complete without consideration of the negative placebo response. The pharmacology literature is almost silent with respect to the negative placebo effect. This silence is understandable, because positive and negative placebo responses are not a property of the drug nor of the quantity administered.

Placebo response is determined by the environment and by the susceptibility of the individual. If nothing could be done about the environment and the patient's psychic makeup, discussion of placebo responses would be purely academic and of no practical value. Fortunately, an understanding and skillful physician can easily manipulate both the environment and the attitudes of the patient. Conversely, the inept physician displays absolutely astonishing clumsiness, whereby he seems almost deliberately to blunder into one negative placebo response after another.

The frequency with which placebo responses occur is far greater than that with which any other pharmacologic response is sought. The fact is, some type of placebo response is elicited in every single patient-physician encounter, whether the treatment given is medical, surgical, or verbal, and also whether we are aware of it or not. These placebo responses may be helpful (positive placebo response) or damaging (negative placebo response).

Both positive and negative placebo responses represent genuine changes in the attitude of the patient, result from his perception of himself and his environment, and are manipulable by other persons (including family, friends, and enemies, as well as physicians).

Let me first give you general examples of negative psychologic responses, then examples specifically applicable to our medical practices.

VOODOO! The word itself conjures up shivers and goose bumps, even in a civilized 20th century man. Voodoo represents a pure and classic form of negative placebo response, since its avowed intent is to inflict harm upon the victim. Whether or not we accept that physical harm can be caused by sticking pins into a doll, there is little doubt that many persons would suffer at least some mental anguish and uneasiness if they were aware that an unknown person is sticking pins into their image.

Most of us know of the trials of the witches in Salem, Massachusetts during colonial days. Probably most of these "witches" were shy and innocent cross-eyed spinsters, but the historical fact is that they were tortured and killed because of the community belief that they were a menace to public health.

The great popularity of demoniacal movies, such as *The Exorcist*, indicates that a substantial number of persons in our present civilization are fascinated by the concept of harm caused by occult means.

In our own practices do we see patients with hysterical amblyopia or other types of conversion hysteria? Do we believe in psychosomatic diseases, or that the phenomenon of hypnotism exists? If so, then we believe also that physical malfunctions can result from psychic manipulations. Let there be no doubt — the negative placebo response is genuine! Furthermore, the negative placebo response can harm not only patients but also their physicians!

Among the more important consequences of the negative placebo response are patient nonwell-being, misdiagnosis, active noncompliance, and medicolegal litigation.

Patient Nonwell-Being

Unlike the deliberate actions of voodoo that are purposefully calculated to induce harm, the negative placebo responses resulting from physician actions are unintentional. Nevertheless, the outcome can be equally devastating.

A classic example was the suicide of a patient several weeks after he was told of the diagnosis of ordinary senile cataract. The physician responsible was not *noted* for tact and gentle-

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Submitted March 26, 1980.

ness. Apparently the message received by the patient was the rather harsh evaluation that the relentless deteriorations of age cannot be avoided, that major eye operations were inevitable, and that there was no certainty that serious complications such as blindness would not result.

I cannot argue that these unpleasant statements are not true. I can object that the message conveyed to the patient should not be the shocking and gloomy picture described by this physician.

When you are still a healthy young physician, it is very easy to have little sympathy for the "crocks and hypochondriacs." Later, when you suffer your own first serious illness, or even if you only *think* you have a dread disease, you will realize that everyone's sense of well-being is seriously compromised when they come face to face with the possibility of their own disability and mortality.

One of my recent patients was a senior medical student, referred for evaluation of a small retinal hole. He had visions of retinal detachment, loss of binocular vision, inability to pursue his chosen career as a surgeon — the whole scenario of doom. My message is that a great many of our patients come to our offices in a frightened and depressed state, well prepared to develop a negative placebo response from nothing more than an expression on our face or a poorly chosen word.

My plea is that such patients should not be managed in an impersonal, highly scientific, aloof, precise, arm's-length manner. Rather, these patients need reassurance, which can be defined simply as "an acceptable and credible prediction of the future."

Of course we cannot predict the future, but we can describe what is likely to happen tomorrow and next week and maybe even next year. In our crystal balls we can foresee a great variety of future predictions — some good, some not so good. Choose thoughtfully which of these future occurrences you will share with the patient. Evaluate his responses to what you do and say and proceed into unpleasant areas only as rapidly as the patient can accept and tolerate bad news.

By judicious interspersing of a little good and a little bad, most patients can accept the need for a major eye operation within a half hour or less of discussion. Some patients cannot accept a major problem so quickly and I must confess that an occasional retinal detachment patient will not permit me to operate on him.

You cannot reassure everyone. However, the only way to reassure is to seek a prediction of the patient's future that is both credible to him and acceptable to him in his present state of mind. What is "acceptable" may change rapidly — even within minutes — as the patient examines his options.

Misdiagnosis

The manifestations of patient nonwell-being mislead the physician and modify his professional behavior. Intellectually, we accept the great importance of a careful history and of detailed scrutiny of the patient's behavior. On a subconscious, body-language level we receive emotional messages as to the status of our patient.

When confronted with a patient manifesting a negative placebo response, our reflex reaction is to become uneasy and to search for an organic problem. This search itself generates an intensified negative placebo response, leading into a vicious cycle of physician and patient responses. A young physician in a University Center is particularly vulnerable to this trap.

As an example, a 75-year-old widow from a nursing home suffered from serious cardiovascular disease and obesity. Following an operation for an emergency retinal detachment under general anesthesia, she responded with nausea and depression. Had she been a healthy teenager, any experienced nurse would have made the obvious diagnosis of "homesickness" and would have treated it effectively with a little tender loving care.

Unfortunately, she received 10 mg of Compazine,® continued to complain, felt faint, and was found to have mild hypotension, so the nurse called the resident who passed the buck to a medical resident consultant. Obviously, he had to rule out myocardial infarction and pulmonary embolism, so she was transferred to the medical intensive care unit for cardiac monitoring, serial enzyme studies, and lung scan.

All these studies were reported as "borderline." (What else would you expect in a tired old lady convalescing from surgery and general anesthesia and homesickness?) After a week she hadn't died yet, so she was sent home with a $3,000 bill from the hospital and not even the courtesy of a medical note to the nursing home or her local physician. Unfortunately, this is not an isolated or rare incident in the ivory tower.

Noncompliance

It is bad enough that the negative placebo effect makes patients feel bad and that it complicates the physician's diagnostic tasks. Worse, it is responsible for the patient's failure to follow medical advice. If you do not follow medical advice, you cannot be helped by even the most advanced, accurate, and effective medical science.

Noncompliance is of two types: passive and active. Passive noncompliance just happens in accordance with Murphy's Law, that if anything can go wrong it will. Patients forget to take their medicine just as we forget to stop for a load of bread on the way home. And legitimate excuses do occur.

Active noncompliance is a deliberate decision not to follow the physician's orders because of any of a large number of reasons: the drops burn; the drops blur vision; the required package insert describes frightening adverse side effects; the physician seemed uncertain as to the diagnosis or management of the condition; the physician did not seem interested in the patient and did not take enough time in examination or explanation; for some reason the patient does not like the physician or his attitudes; reading or talking with friends suggests that some alternate method of therapy is better (this can include quackery such as some of our legalized paramedical cults).

A very high proportion of the reasons for active noncompliance are classifiable as consequences of the negative placebo response. Before you conclude that positive and negative placebo responses are a lot of garbage and have no place in your own practice of scientific medicine, please question whether noncompliance with your instructions makes any difference to your patient's health.

Medicolegal Litigation

Why do some patients sue while others do not, although the nature of the medical problem seems virtually identical in the two cases? Quite obviously, the answer is not just because a bad result occurred, for the nature of disease is that many bad results will inevitably occur. In almost all bad results, lawsuits do not follow.

Are the lawsuits because mistakes are made by the physician? Fortunately, this is not the case either. I like to believe that I have performed at a 95% level during my educational and professional career, which is considerably higher than most persons attain. The converse of this is that my performance is faulty 5% of the time. In private, I am willing to concede a 5% failure rate — I don't fail on purpose, but I can't seem to do better than 95%. Clearly, patients do not sue because the best performance of which the physician is capable falls short of 100%.

Do patients sue physicians to obtain money? Perhaps sometimes. Lawyers almost always bring suits for money — that's the way they make their living. None of the suing patients I have talked to have initiated their actions for money. In every single instance they have been motivated by annoyance with the physician. Their goal is to seek revenge or teach him a lesson so that he will not repeat the same actions with future patients. Medicolegal litigation almost always is the result of a serious breakdown in delicate interpersonal relationships. It could be defined as the backlash of a negative placebo response.

On occasion I have probed the attitudes of patients who knew their bad result was clearly the fault of a substandard physician performance. So long as the patient perceived that the physician seemed honestly interested in the patient and "tried to do his best," none of these patients showed the slightest inclination to sue. Therefore, I classify malpractice litigation as arising primarily from a negative placebo mechanism. Not only the patient, but also the physician and other attending personnel can be harmed by this destructive phenomenon.

Prevention

I hope that I have convinced you that the negative placebo response is very real and worth avoiding. It is avoided by purposefully inducing a positive placebo response. This is done by means of reassurance therapy, which requires six straightforward steps, as follows:

Step one of reassurance therapy is simply a standard medical history. Do not attempt to reassure the patient while taking a history — such attempts are counterproductive by inhibiting the patient from giving you future information and by betraying your anxiety or impatience. In fact, permitting the patient to experience some anxiety during the history preconditions him to accept reassurance therapy more effectively at the appropriate time. (Remember that reassurance therapy requires six steps — it will not work otherwise.)

Step two is evaluation of affect. This evaluation is to be performed during the same time that you are taking the history. Affect is evaluated nonverbally, by interpretation of "body language." Tone of voice, the ease of apprehension of the patient, and his mannerisms convey affect more than do his words. When you realize that you feel uneasy with a patient, he has successfully conveyed to you his concern about his problems.

Evaluation of affect is important because it shows you the significance of the symptoms of the patient and guides you as to how much reassurance therapy will be needed.

Step three is examination of the affected part. It is not only a necessity of physical diagnosis, but it also "talks" to the patient. The gentleness and assurance of your physical contact contributes significantly to his evaluation of your ability. Touch carefully — remember your touch "talks" nonverbally to the patient.

Step four is medical diagnosis. You must accurately assess the nature of the patient's problem. Note that the patient cannot judge your accuracy or your knowledge. This step will, of course, determine the definitive medical care you render to the patient.

Step five is explanation. You will misunderstand this step. Although an explanation of the problem is a necessary part of reassurance therapy, is basic to the legal doctrine of informed consent, and is essential to the cooperation of your patient in therapy, it is not essential that the patient understand your explanation to be reassured. The explanation must, however, convey three beliefs to the patient:

1. Belief that the physician understands the symptoms.
2. Belief that the physician is not uncertain about the management of the symptoms. (Do not undermine yourself by spontaneous small talk that shakes the patient's confidence; keep your mouth shut during the indecisive period of your thinking about the evaluation and management.)
3. Belief that the physician is sympathetic (that is, not antiseptic in manner) and wants to be helpful.

Only as the sixth and final step is reassurance appropriate. What is reassurance? Is it saying, "Oh, don't worry"? Did you ever see anyone worry less after such an admonition?

Reassurance may be defined as a credible and acceptable prognosis. Predict the patient's future appropriately. Be as specific as possible with respect to the patient's particular situation. What can he do and what can he not do? Seek out and stress all positive aspects. Do not volunteer negative and threatening facts unless he must know them (for example, informed consent to surgery requires general knowledge that not every operation is successful). Do not be unrealistic — future problems arise if the patient's expectations exceed the physician's ability to deliver. Banish unwarranted fears — patients usually imagine worse problems than actually exist.

Conclusion

There is the story of the psychologist who committed suicide with an overdose of a negative placebo. You may not believe that particular apocryphal tale. However, I hope you will believe my classification of a negative placebo as being one of the most toxic and destructive elements within the practice of medicine. Consciously avoid the negative placebo response in every patient. Ignore this admonition at your peril!



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Beep . . . beep . . . beep!

American physicians have become obsessed with gadgetry and complicated equipment, both mechanical and electronic. The average intensive care room becomes impassable for the myriad tubes, wires, machines and colored lights. One can always hear the ubiquitous "beep."

When asked by an anxious patient what the beep meant, an orderly replied, "I don't know, but if it stops beeping you'd better get up and run, because they'll be in here beating hell out of you." — **Atlanta Medicine** (July, 1980).

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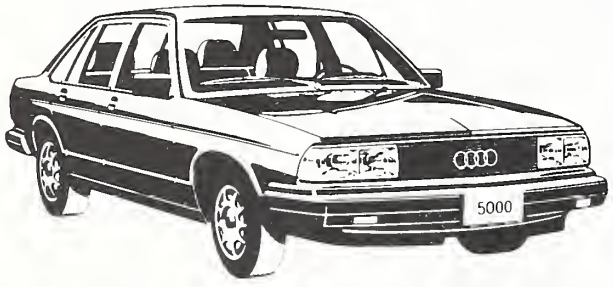
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Letters ...to the editor

To the Editor:

I recognize letters are occasionally published, but don't truly expect this one to be, though I would welcome it.

I wish to complain about the utilization of the entire Ohio State Medical Journal for political news and trivia involving officers and staff. There was a day when scientific articles were seen, but I understand the editor was limited to no more than two articles. I recognize that there is no pretense that the Ohio State Medical Journal is equal to the New England Journal of Medicine, but with the large number of medical schools in the state, the population and medical base, and the fact that medicine is more than interacting with government and insurance agencies, it would seem logical to consider a few scientific papers for the Journal.

Indeed, I believe there should be a split with a scientific editor and the staff having two separate functions, but at this time the staff seems to dominate the entire Journal as far as selection of articles and inclusion of what would be of interest to the physicians in the state. Instead of being one of the major rewards for being a member of the OSMA, the Journal is a financial liability to many of the physicians in the state who are more concerned with scholarly aspects of medicine than with what is happening in the political arena. I do not pretend that I am in this group of intellectual physicians but I know they exist and I do not believe they are being adequately served at this time by the Ohio State Medical Journal.

Sincerely yours,
/s/George Paulson, M.D.

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COLLEAGUES IN THE NEWS

KENNETH L. AKINS, M.D., Port Clinton, was elected chief of staff of H.B. Magruder Hospital. Other officers include **WILLIAM T. COON, M.D.**, vice president, and **G. V. CRISOLOGO, M.D.**, secretary-treasurer.

BRUCE A. BAKER, M.D., Logan, was appointed Medical Director of the physical therapy department at Doctors Hospital of Nelsonville. Dr. Baker is a physiatrist and currently is director of behavioral medicine at University Hospital in Columbus.

NESTOR V. BANEZ, M.D., Massilon, was elected president of the Massilon Community Hospital medical staff. Also elected were **ALFRED DeSANCTIS, M.D.**, president-elect, and **DAN R. QUEENER, M.D.**, secretary- treasurer.

L. J. BUJDOSO, M.D., Lisbon, was named vice president of the medical staff at Northern Columbiana County Community Hospital.

W. R. ROUSSEAU, M.D., Salem, was named secretary, and **D. W. DRAKE, M.D.**, Salem, treasurer.

JEFFREY BULLARD, M.D., Painesville, was presented an award as physician of the year at Lake County Memorial Hospital. Dr. Bullard has been an internist on the hospital staff since 1978.

KENT BROWN, M.D., Cleveland, was elected president of the Vincent Charity Hospital medical staff. Dr. Brown specializes in general and trauma surgery and is an assistant clinical professor at Case Western Reserve University Medical School.



Oscar Clarke, M.D.

OSCAR W. CLARKE, M.D., Gallipolis, was elected vice president of the State Medical Board. Anthony J. Ruppersberg, M.D., Columbus was appointed secretary-treasurer. Dr. Clarke currently serves as chairman of the Ohio Delegation to the AMA and is past president of the OSMA. Dr. Ruppersberg is chairman of the OSMA Maternal Health Committee.

GORDON N. FARNER, M.D., Maple Heights, was elected president of the Marymount Hospital medical staff. Dr. Farner specializes in orthopedic surgery. Other officers include: **CHARLES M. BRANDEN, M.D.**, president-elect; **JOHN J. MARGRETT, M.D.**, secretary; and **WILLIAM E. BRUCK, M.D.**, treasurer.

LAWRENCE C. GOLDBERG, M.D., Cincinnati, was honored by the Dermatology Foundation as "Practitioner of the Year." Dr. Goldberg has been a specialist in dermatology for 48 years, is past president of the Cincinnati Dermatological Society, and is active in numerous major medical organizations. He has introduced into skin disease treatment 26 drugs which have been adopted world-wide, and is author of more than 200 scientific papers on skin disease.

EMILY HESS, M.D., Cincinnati, was honored by the Southwestern Ohio Speech and Hearing Association for her "provision of total patient care" and for bringing speech and hearing services into a hospital setting. Dr. Hess developed Good Samaritan's Rehabilitation Medicine Department and initiated the first full-time hospital Speech Pathology Department.

Five physicians received awards for 25 years of service at St. Charles Hospital, Genoa. Honored for being on the medical staff since 1955 were **VICTOR ISKERSKY, M.D.**, family practice; **LEONARD NIPPE, M.D.**, ophthalmology and otolaryngology; **JACK M. SCHECHTER, M.D.**, psychiatry; **NDOC SHLLAKU, M.D.**, family practice; and **LESLIE E. WHITMIRE, M.D.**, psychiatry.

EDWARD F. KIEGER II, M.D., Cleveland, was elected president of the medical staff at St. Alexis Hospital. Dr. Kieger specializes in vascular surgery.

BRIAN D. LOWERY, M.D., Columbus, was elected president of the Ohio Thoracic Society. Dr. Lowery is an associate professor of surgery at Ohio State University College of Medicine. Also elected were **DAVID J. DORTIN, D.O.**, Cincinnati, vice president, and **CHARLES B. PAYNE, JR., M.D.**, Dayton, secretary-treasurer.

DONALD W. LENHART, M.D., Sandusky, was elected president of the medical staff of Providence Hospital. Dr. Lenhart, a surgeon, has served as vice president for the past two years. Other officers elected were **ALBERT O'HALLORAN, M.D.**, vice president, and **KYUNG H. KIM, M.D.**, secretary-treasurer.

JOHN M. McLAUGHLIN, M.D., Westlake, was elected president pro tempore of the medical staff of St. John and West Shore Hospital. **EDWARD G. KILROY, M.D.**, was elected secretary-treasurer pro tempore.

Continued on Page 120

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AKRAM NAJIB, M.D., Canton, was elected president of Timken Mercy Medical Center's medical staff. Dr. Najib is a cardiovascular thoracic surgeon. Other officers elected include **JOHN D. BOTTI, M.D.**, president-elect, and **GRACE HOFSTETER, M.D.**, secretary-treasurer.

MARIANO PIZARRO, M.D., Solon, was elected to the board of trustees of the Community Hospital of Bedford. Dr. Pizarro has been on the medical staff of Bedford Hospital since 1968.

HOWARD E. SANDERS, M.D., Springfield, was elected president of the staff of Mercy Medical Center. Dr. Sanders, an internal medicine specialist, has been an active member of the staff since 1950. Also elected were **RAYMOND W. COOPER, M.D.**, president-elect, and **SALLY A. ABBOTT, M.D.**, secretary-treasurer.

JOSE D. SOMERA, M.D., Bedford, was elected president of the Community Hospital of Bedford medical staff. Dr. Somera is a general practitioner and has been on the Bedford Hospital staff since 1963. Also elected were **DANIEL DESBERG, M.D.**, president-elect, and **SUKUMAR ROY, M.D.**, secretary-treasurer.

WILLIAM SOVIK, M.D., Youngstown, was reelected president of the clinical staff of St. Elizabeth Hospital Medical Center. Also reelected were **WILLIAM CRAWFORD, M.D.**, vice president, and **RICHARD RICHARDS, M.D.**, secretary-treasurer. Dr. Sovik, a member of the hospital staff more than 30 years, is former president of the Mahoning County Medical Society, and has been active in professional organizations at the national, state, and local levels.

Dr. Crawford, a staff member since 1975, is the hospital's director of education in radiology and is an associate professor of radiology at the Northeastern Ohio Universities College of Medicine.

Dr. Richards has been with St. Elizabeth's since 1966 and has been director of the department of anesthesia since 1970.

WALTER J. TIMS, M.D., Youngstown, is the Mahoning County Medical Society's "Doctor of the Year." Dr. Tims, a proctologist, received the award from his colleagues for his outstanding contributions to the community, especially as health commissioner from 1948 through 1953.

KENNETH L. WEHR, M.D., Cincinnati, was elected chief of staff at Mercy Hospital North. Dr. Wehr is an internist and has been a member of the medical staff at Mercy North since 1975. **THOMAS U. TODD, M.D.**, was named chief of staff at Mercy Hospital South.

FLORENCIO E. YUZON, M.D., was reelected chief of staff at Lorain Community Hospital. Other officers elected include: **STEPHAN M. TICICH, M.D.**, vice president; **FRANCIS A. BARTEK, M.D.**, representative to the governing body; and **VICTOR M. SANDOVAL, M.D.**, chief of pediatrics.

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STATE

MEDICAID BUDGET BEFORE HOUSE FINANCE COMMITTEE

With the biennial budget currently under review by the Ohio House Finance-Appropriations Committee, the OSMA is actively communicating with state legislators its concern with the financial difficulties of the state's Medicaid program. These continuing difficulties are eroding the ability of Medicaid beneficiaries to obtain quality medical care and treatment.

Physician fee schedules used by the Ohio Department of Public Welfare for the Medicaid program have not been systematically updated since 1969. The U.S. General Accounting Office (GAO) investigated the Ohio Medicaid program in 1978 and issued a report based upon its findings. The report stated: "Ohio does not regularly update its fee schedule amounts to reflect inflation, except for prescription drugs, because it lacks the funds to pay the resulting increases. Medicaid program officials would probably not be facing these problems if the State did not use the fee schedule updating function as a cost containment measure."

As are most other state and local governments, the State of Ohio is experiencing severe budgetary difficulties. A one-half billion state deficit in the current biennium was overcome through the reluctant imposition of several "temporary" tax increases for the period January 1, 1981, through June 30, 1981. The executive budget proposed by the Rhodes administration for the coming biennium (July 1, 1981 through June 30, 1983) projects a shortfall in state revenues producing personnel cutbacks and limited increases in the funding of state agencies. The temporary taxes are repealed.

Despite the state's fiscal difficulties, legislators voting on the provisions of the budget must be made aware of the harmful consequences, both to Medicaid beneficiaries and to the state, of continued use of the provider fee schedules as a passive cost-containment measure. Federal Medicaid requirements mandate that the state Medicaid program enlist the participation of a sufficient number of providers in the program so that beneficiaries can receive covered medical services to the extent they are available to the general population. This provision is one of several designed to ensure that the poor are not relegated to a separate, second-class system of medical care. However, the current fee schedule, the absence of any effective mechanism in Ohio to periodically review and update Medicaid fee schedules, and delays in payments to providers, discourage physicians from participating in the state Medicaid program. The result of these program disincentives is to leave Medicaid beneficiaries with no alternative but to seek medical care in the expensive hospital emergency room setting.

In the last year alone, more than fifty-two (52) million Medicaid dollars were paid out to hospital outpatient clinics and hospital emergency rooms, which are reimbursed on the basis of cost. The Medicaid office reports that 1,215,890 of this type of claim were filed for an average visit cost of approximately forty-two ($42) dollars. During the same time period, physicians participating in the Medicaid program submitted 2,325,622 claims for a total cost of sixty-two (62) million dollars. The average cost of a physician claim, including surgery and other medical procedures, was only twenty-six ($26) dollars. On the average, then, hospital outpatient visits were more than 60% more expensive than visits to physicians' offices in 1980.

The reluctance of the State of Ohio to increase provider reimbursement effectively takes physicians out of the Medicaid program, and, in so doing, jeopardizes the quality of care for Medicaid beneficiaries and costs the state money. Members of the Ohio General Assembly must be made aware of these consequences as they deliberate over the biennial budget. The problems of the Ohio Medicaid program will only be compounded by the poor economic situation currently facing the state.

Members of the House Finance-Appropriations Committee, who should be contacted personally by OSMA members and auxilians, are the following:

Myrl Shoemaker (D-Bourneville)-Chairman
William Hinig (D-New Philadelphia)-Vice Chairman
Robert Boggs (D-Jefferson)
Thomas Bell (D-Cleveland)
Dean Conley (D-Columbus)
Pete Crossland (D-Akron)
Fred Deering (D-Monroeville)
Thomas Gilmartin (D-Youngstown)
Casey Jones (D-Toledo)
C. J. McLin (D-Dayton)
Robert Nettle (D-Barberton)
Francine Panehal (D-Cleveland)
Helen Rankin (D-Cincinnati)
Pat Sweeney (D-Cleveland)
John Wargo (D-Lisbon)
Joe Williams (D-Niles)
*Tom Johnson (R-Cambridge)
Claire Ball (R-Athens)
Robert Brown (R-Perrysburg)
Robert Corbin (R-Dayton)
Joann Davidson (R-Reynoldsburg)
Michael Fox (R-Hamilton)
Richard Maier (R-Massillon)
Robert Netzley (R-Laura)
Robert Ney (R-Bellaire)
Thomas Pottenger (R-Cincinnati)
*Denotes ranking minority member

CONGRESSIONAL HEALTH AGENDA

A number of expiring laws and authorizations set a basic "health agenda" for Congress this year. Expiring authorizations include programs in the following areas: health services, statistics and technology research, grants to states for health services including comprehensive public health grants, state mental health programs, lead-based paint poison prevention, project grants for preventive health services, venereal disease programs, primary care centers, migrant health centers, community health centers, home health services, primary care research and demonstration projects, medical libraries, family planning, genetic disease, sudden infant death syndrome, hemophiliac programs, health maintenance organizations, alcohol abuse programs, drug abuse programs, and all physician and nurse training programs.

Legislative direction from the Reagan administration will come from the new Secretary of Health and Human Services, Richard S. Schweiker. The former Republican Senator from Pennsylvania, commended by both Democrats and Republicans for his knowledge of national health and welfare matters, was unanimously confirmed by the Senate.

During confirmation hearings, Schweiker indicated a top priority of his department would be an evaluation of the cost effectiveness of the PSRO program. He said the "preliminary figures on PSRO are very discouraging and indicate that the program costs $30-$50 million more than it saves."

Addressing questions regarding national health insurance legislation, Schweiker said "because of budgetary considerations, if health insurance legislation were passed at all, it would be a catastrophic program in combination with a fill-in-the-gaps approach."

THREE OHIO REPS ON HOUSE HEALTH SUBCOMMITTEES

Three Ohio congressmen sit on the two major health subcommittees of the U.S. House of Representatives in this 97th Congress. Rep. William Gradison (R-Cincinnati) is the ranking minority member of the Health Subcommittee of the House Ways and Means Committee. Rep. Thomas Luken (D-Cincinnati) and Rep. Clarence Brown (R-Urbana) are among the eighteen members of the Health and Environment Subcommittee of the House Energy and Commerce Committee (formerly the Interstate and Foreign Commerce Committee).

House Ways and Means Health Subcommittee

Democrats

Andrew Jacobs, Jr. (Ind.), Chairman
Charles B. Rangel (NY)
William D. Ford (MI)
Cecil L. Heftel (Hawaii)
Kenneth L. Holland (SC)

Republicans

William Gradison (Ohio) Rank. min.
John J. Duncan (Tenn.)
Phillip Crane (Ill.)

House Energy and Commerce Health and Environment Subcommittee

Democrats

Henry Waxman (Cal.), Chairman
James Scheuer (NY)
Thomas Luken (Ohio)
Doug Walgren (Penna.)
Barbara Mikulski (Md.)
Ron Wyden (Ore.)
James Florio (NJ)
Toby Moffett (Conn.)
Richard Shelby (Ala.)
Phil Gramm (Texas)
Mickey Leland (Texas)

Republicans

Edward Madigan (Ill.) Rank. min.
Clarence Brown (Ohio)
William Dannemeyer (Cal.)
Robert Whittaker (Kansas)
Don Ritter (Penna.)
Cleve Benedict (WV)
Thomas Bliley (Va.)

Senator David Durenberger (R-Minn), sponsor of "pro-competition" legislation last session, is the new chairman of the Senate Finance Committee's Health Subcommittee. The new chairman of the Senate Labor and Human Resources Committee, Orrin Hatch (R-Utah), has terminated the committee's Health Subcommittee. This denies Senator Kennedy a forum on health legislation. All health legislation will be handled at the full committee level.

Senate Finance Health Subcommittee

Republicans

David Durenberger (Minn), Chairman
Robert J. Dole (Kan)
Bob Packwood (Ore)
H. John Heinz (Pa)

Democrats

Max S. Baucus (Mont), Rank. min.
Bill Bradley (NJ)
Russell B. Long (La)

Senate Labor and Human Resources Committee

Republicans

Orrin G. Hatch (Utah), Chairman
Robert T. Stafford (Vt)
Dan Quayle (Ind)
Paula Hawkins (Fla)
Don Nickles (Okla)
Lowell P. Weicker (Conn)
Gordon J. Humphrey (NH)
Jeremiah Denton (Ala)
John East (NC)

Democrats

Edward M. Kennedy (Mass) Rank. min.
Harrison A. Williams (NJ)
Jennings Randolph (WV)
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NEWS

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Meetings

Practical Management of Common Geriatric Problems: March 13-14, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois. Credit: 14 hours, Category I. Common clinical situations will be reviewed in a practical manner, with emphasis on the ways in which diagnostic and pharmacologic practices may differ from those in younger patients. Sponsored by Rush Medical College and Johnston R. Bowman Health Center for the Elderly. Contact: Jennifer Littleton, University Office of Continuing Education, Rush-Presbyterian-St. Luke's Medical Center, 600 South Paulina, Chicago, Illinois 60612, (312) 942-7095.

Medical Assistants 24th Annual State Convention: April 22-26, Sheraton North, Columbus, Ohio. Speakers will include: Andrew J. Pultz, M.D., Herbert Riemenschneider, M.D.; and James Monahan, Esq. For further information, contact: Libby Moore, CMA, 491-5667, or Connie Pailet, 476-2318.

With the OSMA staff



Jerry Campbell, associate executive director of the Ohio State Medical Association, was recently installed as president of the Professional Convention Management Association (PCMA), at its annual meeting in Los Angeles, California.

Mr. Campbell's duties at the Association include the management of several Ohio medical specialty societies, as well as staffing the Ohio delegation to the American Medical Association. He also serves on the board of directors of the Physicians Life Insurance Company.

Jerry Campbell (left), OSMA associate executive director, is seen with PCMA past president Robert Cox.

MISCELLANEA

• The American Medical Association is now offering "video clinics" as an alternative way to earn CME credits without having to make long, out-of-town journeys. A selection of approved courses, in the form of color videotapes, self-assessment tests, and illustrated study guides can be rented or purchased from the Department of Marketing Communications, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610, (312) 751-5951. The Department claims the clinics are convenient, succinct, and permanent, providing opportunities for later review.

• The "who, what, why and where" of Medical Research has been compiled into a single volume by R. R. Bowker Company, entitled "Research Programs in the Medical Sciences, 1981." The book identifies manufacturing and industrial service companies, academic and nonprofit organizations, and independent institutes, all doing research in the medical sciences. The book sells for $79.95 a copy, and further information can be obtained by writing R. R. Bowker Company, 1180 Avenue of the Americas, New York, N.Y. 10036.

The American Scandinavian Student Exchange (ASSE) is looking for American families to serve as hosts to 25 high school students from Sweden, Norway, Denmark, and Finland, during the 1981-1982 school year.

The students, aged 16 and 17, will arrive in the U.S. during late August, 1981, attend the local high school, and return to their home countries in late June, 1982. Language barriers are no problem, as all participants are fluent in English, and each student will have complete medical-liability insurance.

Host families are eligible for a $90 per month "charitable contribution" deduction from their federal income tax. Interested parties should write, including their phone number, to Linda and Terry Blosser, 709 South Blackhoof Street, Wapakoneta, Ohio 45895.

The ASSE also is seeking American high school students, aged 16 and 17, who would like to spend a high school year with a Scandinavian family, or who would like to participate in a six-week family stay in the summer of 1981. Again, for further information, contact the Blossers at the address listed above.

BOOK SHELF

The Economics of Medical Malpractice. *Edited by Simon Rottenberg; the American Enterprise Institute for Public Policy Research.*

The legal and economic implications of various policies affecting malpractice, is examined in this latest book, which asks the central question: "How can society design and administer rules and pricing and incentive arrangements that will cause patients to receive the kind of medical care they desire; will cause the appropriate quantity of caution to be exercised in its delivery; and will achieve those objects at the cheapest possible social cost?"

The book contains papers prepared primarily by economists and law school faculty members with commentaries on each paper presented.

The book is available from the American Enterprise Institute for Public Policy Research, 1150 Seventeenth St., N.W., Washington, D.C. 20036.

Stress, Work, Health. *Edited by J.F. McCahan, M.D. and R. H. Wheater. AMA Publications.*

This latest booklet from the AMA is aimed at providing information for the physician who must deal with stress in the workplace, and how it affects individuals. The book is a compendium of short articles by a number of experts who deal with stress as an occupational health hazard.

But, as James R. Kelsey, M.D., an occupational health physician of Omaha, Nebraska points out, "Stress is positive when you can handle it, rather than having it handle you; when stress becomes excessive or the individual is unable to adapt, it may cause anxiety, fear, even physical disease."

The book is available from AMA Publications, P.O. Box 821, Monroe, Wisconsin 53556.

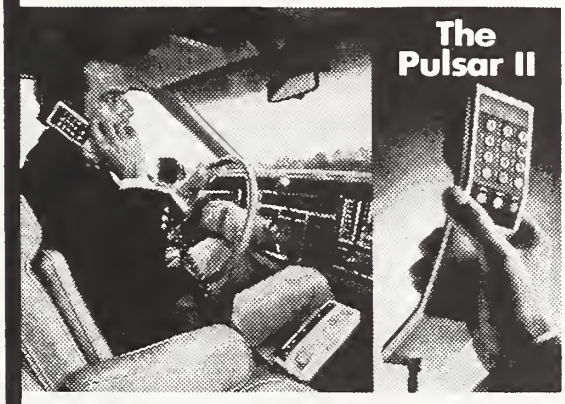
Standard Nomenclature of Athletic Injuries. *Edited by Jack Bell. AMA Publications.*

Prepared by a panel of authorities in sports medicine under the auspices of the AMA's Council on Scientific Affairs, this updated edition is designed to help physicians arrive at a standard diagnosis of abrasions as well as hundreds of other sports injuries.

The book covers such diverse conditions as anxiety, heat stroke, and tennis elbow. It gives the common name of the injury, additional names by which it is known, possible cause, symptoms, physical signs, complications, and other aspects.

The book is available from AMA Publications, P.O. Box 821, Monroe, Wisconsin 53556.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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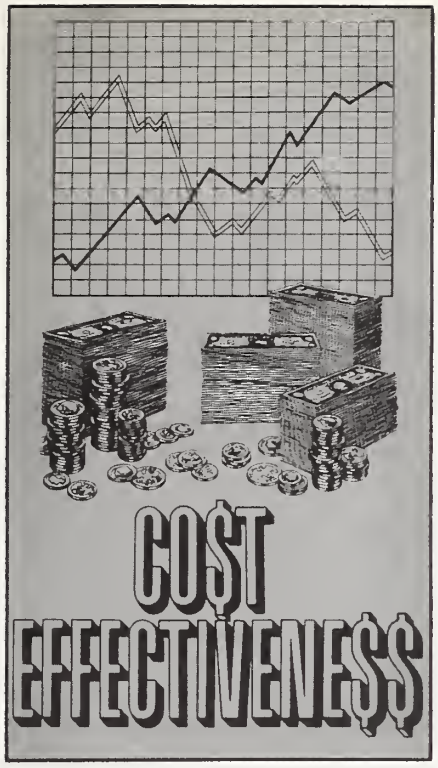
Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



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A look at a new program launched in Cincinnati which is releasing hospital patients . . .

One Day Early

By Karen M. Cooper

Editor's Note: When the Health Care Task Force of the Academy of Medicine of Cincinnati met for a "brainstorming session," there was some doubt as to how successful it would be.

Of course, there was plenty of talent sitting around the table. Representatives from business, labor, the health insurance industry, health systems agency, hospital council, United Way, county government, and the university medical center all could throw in ideas from their respective viewpoints. But what new approach could possibly be found to the subject of cost containment? After all, it's a subject that has been of national and local concern since 1979, and much has already been done.

But not quite everything. That day, the Task Force hatched an idea for a "One Day Early" program in which physicians, with the cooperation of hospital administrators and health insurers, are encouraged to release patients admitted to the hospital for uncomplicated medical diagnoses or surgical procedures one day early.

The program actually began on January 2, 1980, with a meeting that brought together the president of Bethesda Hospitals; its present and immediate past chiefs of the medical staff; the executive directors of the private and government utilization review organizations; plus representatives from Blue Cross of Southwest Ohio, and the Health Insurance Association of America.

During this meeting, agreement was reached to proceed with a reduced length of stay program. Two major considerations were discussed: one related to physician control of the program, and the other to participation of health insurers. A Physician Advisory Committee was established to administer the program. Physician direction was acknowledged as crucial if physicians and their practice patterns were to be influenced.

This Physician Advisory Committee is chaired by Bethesda Hospitals' Director of Utilization Review, and includes some physicians of the hospital's utilization review committee, along with a representative of the Academy Council. Once formed, this committee immediately began selecting the diagnoses to be included in the program and developing the procedures to accomplish reduced stays.

The second major consideration was enlisting the cooperation of the health insurance industry. A patient discharged one day early is entitled to outpatient aftercare procedures, if the procedures would have prolonged the hospital stay. Blue Cross did not hesitate to sign up for the One Day Early program because this program complemented their own efforts to develop a reduced stay program. Enrolling the private health insurance carriers into the program proved a greater challenge.

Each of 11 insurance companies was approached individually; local representatives often had to solicit home office approval in another part of the country. Finally, eight private insurance companies agreed to join the program; they will pay for aftercare procedures to be performed within one week following discharge. In return, they are supplied with quarterly data concerning their subscribers' diagnoses and lengths of stay.

Those insurance companies participating are: Provident Life and Accident Insurance Company, Prudential Insurance Company of America, John Hancock Mutual Life, Travelers Life Insurance Company, Connecticut General Life Insurance, Union Central Life Insurance, Massachusetts Mutual Life Insurance, and Aetna Life and Casualty. Three others refused to join the program.

ODE IN OPERATION

When a patient is admitted with a diagnosis/procedure qualifying for participation in ODE program, the admitting physician is informed of this eligibility by a notice attached to the front of the patient's chart. The notice, a letter from the chairman of the One Day Early Physician Advisory Committee, explains the program and lists the regional average length of stay for patients of that same age and same diagnosis. This gives the physician a target for a one day early discharge.

The Quality Assurance Department of Bethesda Hospitals monitors the length of stay through the utilization review nurses who, on their daily rounds, post reminders to physicians as the target discharge date approaches. The physician makes the final assessment to determine the advisability of early discharge and is

assisted in discharging the patient by hospital personnel, who arrange for any necessary aftercare procedures ordered by the physician.

A special billing form for the One Day Early program is initiated as the patient is being discharged. The patient receives a copy which includes the appointment day and time for the aftercare procedure. The other copies go directly to the outpatient registration area where the patient returns within seven days for the procedure. The completed One Day Early billing form then is sent to patient accounting. If the patient does not appear for the scheduled aftercare, a nurse in the outpatient department contacts the patient to assure follow-up.

PRELIMINARY RESULTS

During the first three months of the program, 338 patients were admitted into the One Day Early program. Because of early discharge, 812.3 days were saved, an average savings of 2.4 days per patient. The program's effectiveness is evident not only in these preliminary findings, but also in the growing awareness among physicians of the regional average hospital length of stay and their own length of stay patterns. OSMA

Karen M. Cooper is the Health Planner for the Academy of Medicine of Cincinnati.

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CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies; patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

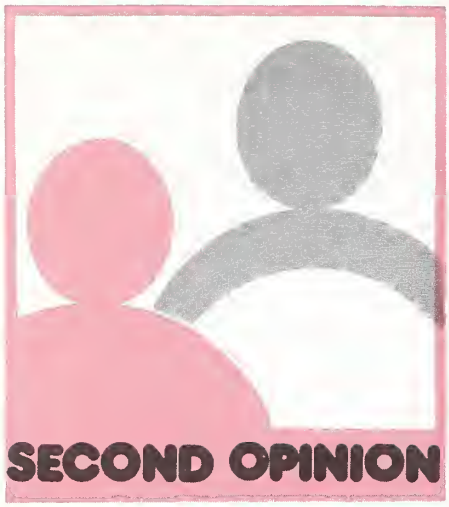
The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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Maintaining Quality Care

By Timothy Moritz, M.D.

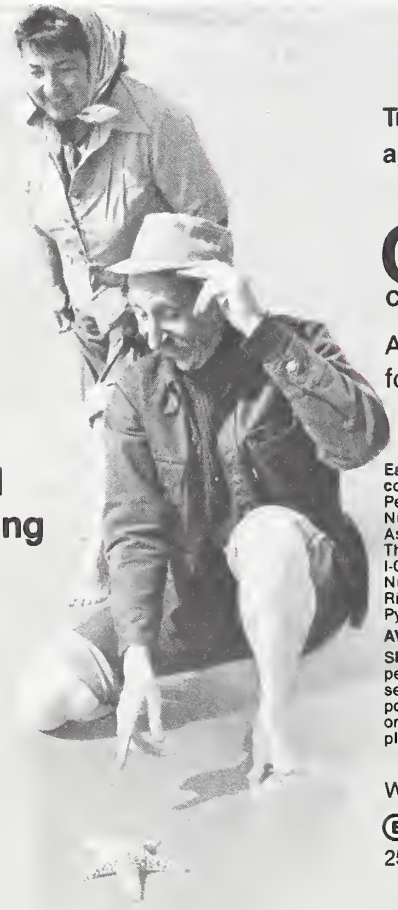
Editor's Note: When this article was written, Dr. Moritz was serving as director of the Ohio Department of Mental Health and Retardation. He left that office effective February 1 of this year.

Over the past decade, there has been considerable progress in improving the care and treatment provided to patients in Ohio's state mental hospitals. However, we have not yet achieved our goal of having all of these hospitals comply with minimal national professional standards.

There is serious concern that the current economic recession may cause the state government to abandon or indefinitely postpone its efforts to provide minimally acceptable care and treatment to mentally ill individuals in its hospitals.

It is important that the state act promptly to provide adequate funds for these hospitals and competitive salaries for the professionals required to staff them. Failure to do so could lead to loss of critically needed professionals and deterioration of the quality of care. If this is permitted to happen, it would take years to rebuild the professional staff of these hospitals to even the current levels.

The medical profession should vigorously support these efforts, insisting on adequate professional standards in our public hospitals and adequate medical input into community mental health programs. Substandard medicine should not be tolerated anywhere, but most of all it should not be permitted to exist in our government's own hospitals, where many patients are confined against their will.



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OSMA 1981 Annual Meeting

Involvement: Hallmark of our profession

Involvement — Hallmark of our Profession is the theme chosen for the 1981 Ohio State Medical Association Annual Meeting, May 16-20, 1981.

The Annual Meeting will be held in Cleveland, Ohio at Stouffer's Inn on the Square and Bond Court Hotel, May 16-20.

Have you been putting off a course in CPR? Don't delay — Basic Life Support will be offered on Saturday afternoon, May 16. The Advanced Life Support is a two-day course offered on Sunday, May 17, and continued on Monday, May 18. Certification in Basic Life Support is a prerequisite for the Advanced CPR Course.

Do you need to improve your English pronunciation? There is a course especially designed to assist foreign physicians now in practice in the United States in improving spoken communications with their patients. Participants should have a good working knowledge of English vocabulary and grammar. The one-day program serves as a guide for further work at home with a 134-page study guide text and nine audio tapes. This course is offered on Saturday, May 16.

Don't forget the importance of a well-trained office staff. Remember, they represent you and are a very important part in the physician-patient relationship. Your image is important. Several programs offered on Saturday, May 16, may be just what your support staff has been needing to attend. A program for the Office Manager — Team Building, is designed for the physician's office supervisor. In addition, programs for the Telephone Manager and How to Schedule the Doctor's Time will be offered, as well as a program for the physician on Personal Financial Planning.

Postgraduate Courses on Electrolytes and Blood Gases, Office Care for the Older Persons, and Drug Therapeutics, are several programs being offered. In addition to these, a multitude of subjects will be covered by virtually every specialty. This is your opportunity to attend.

The traditional Ohio Medical Political Action Committee (OMPAC) luncheon will be held on Tuesday, May 19. Roger Ailes, well-known TV producer and communications expert will speak at the OMPAC luncheon.

Although this is a mere sampling of the many activities planned for the 1981 OSMA Annual Meeting, the April issue of the Journal will contain a more complete schedule of events. In addition, a preliminary program will be mailed to all OSMA members one month prior to the Annual Meeting.

Mark your calendar NOW! Let's get involved.

May 16 – 20, 1981, Cleveland

Headquarters Hotel — Stouffer's Inn on the Square, 24 Public Square, Cleveland 44113
Coheadquarters Hotel — Bond Court Hotel, E. Sixth at St. Clair Avenue, Cleveland 44114
Auxiliary to OSMA Headquarters Hotel — Hollenden House, E. Sixth & Superior, Cleveland 44114
Resource Center — Stouffer's Inn on the Square
Photographic Exhibit — Stouffer's Inn on the Square

Saturday, May 16, 1981

Registration	7 AM – 1 PM
Psychiatry	8 AM – 5 PM
Starting Your Practice (2-day course)	8:30 AM – 4:30 PM
Team Building (Physician's Office Supervisor)	8:30 AM – 4:30 PM
You, The Telephone Manager	9 AM – 12 NOON
Improving English Pronunciation	9 AM – 5 PM
Basic Life Support	1 – 5 PM
The Doctor's Time and How to Schedule It (Office Personnel)	1 – 5 PM
Enhance Your Skills for Personal Financial Planning (for Physicians)	1 – 5 PM

Sunday, May 17, 1981

Advanced Life Support (2-day course)	8 AM – 5 PM
Starting Your Practice (continued from Saturday)	8:30 AM – 4:30 PM
Resource Center	2 – 7 PM
OSMA Delegation to AMA	2 – 4 PM
House of Delegates	
Registration	3 – 7 PM
Buffet Dinner: Delegates, Alternates, OSMA Council, and Official Guests	5:30 PM
First Business Session	7 – 9 PM
Councilor District Caucuses	4 – 5:30 PM

Monday, May 18, 1981

Complimentary Buffet Breakfast	7 – 8 AM
Reference Committee Meetings Resolutions Committee 1 Resolutions Committee 2 Resolutions Committee 3 President's Address Nominations	7:30 AM
Advanced Life Support (continued from Sunday)	8 AM – 5 PM
General and Advance Registration	8:30 AM – 5 PM
Neurology	8:30 AM – 12:30 PM
Otolaryngology	8:45 AM – 4:30 PM
Resource Center	9 AM – 4 PM
Rheumatology	12 NOON – 5 PM
Neurosurgical	2 – 4 PM
Marketing and Competition	2 – 4 PM

Tuesday, May 19, 1981

Postgraduate Courses Course 1: Electrolytes & Blood Gases Course 2: Office Care for Older Persons Course 3: Drug Therapeutics	7:30 – 10:30 AM
OMPAC Board Breakfast	8 – 11 AM
Ophthalmology	8 AM – 5 PM
General and Advance Registration	8:30 AM – 5 PM
Resource Center	9 AM – 4 PM
Pfizer Dialogue	9 AM – 4 PM
Neurosurgical	9 AM – 4 PM
Ohio Committee on Trauma, A.C.S.	9 – 11:30 AM
Pathology	9 AM – 4:30 PM
Internal Medicine	9 AM – 12 NOON
Pediatrics	9 AM – 1 PM
Physical Medicine	12 NOON – 4 PM
OMPAC Luncheon	11:30 AM – 2 PM
Emergency Medicine	2 – 5 PM
OSMA Social Function	6:30 PM

Wednesday, May 20, 1981

Postgraduate Courses Course 1: Non-Invasive Techniques Course 2: Alcoholism Course 3: Sports Medicine	7:30 – 10:30 AM
General and Advance Registration	8:30 AM – 5 PM
Hospice Program	8:30 – 10:30 AM
Allergy and Immunology	8:30 AM – 2 PM
Sports Medicine **(at Cleveland State University)**	8:30 AM – 4:30 PM
Occupational Lung Disease **(at Cleveland Clinic)**	8:30 AM – 4:30 PM
Resource Center	9 AM – 12 NOON
Plastic Surgery	9 AM – 2 PM
Colon & Rectal Surgery	11:30 AM – 5 PM
Anesthesiology	1:30 – 4:30 PM
House of Delegates	
Registration	2:30 – 3:30 PM
Final Business Session	3:30 – 6 PM
Buffet Dinner: Delegates, Alternates, OSMA Council, and Official Guests	6 PM
Final Session (continued)	7 – 10 PM

Thursday, May 21, 1981

OSMA Council Meeting	8:30 – 10 AM



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Health Planning-

By Karen S. Edwards

When federal legislation mandated health planning agencies several years ago, a number of physicians turned their backs and refused to get involved. One Ohio physician took another tact. Here, he explains why.

Alford C. Diller, M.D., of Van Wert, Ohio, has been an active member of health systems agencies (HSAs) almost since their inception. It has not always been a popular role to play.

"When the federal government mandated health planning several years ago, a number of physicians viewed it as just another attempt by the government to intervene in the practice of medicine. Many of them refused to get involved," says David Pennington, Director of Health Planning for the Ohio State Medical Association.

"Unfortunately, that only meant that health planning was going to be implemented without physician input. Obviously that's not the solution. The only way to decrease government involvement is to increase physician involvement," he says, and such involvement came from Dr. Diller.

Dr. Diller was elected to his first three-year term on the local HSA Board in March, 1976. He served as president of the HSA board from March, 1978 to March, 1980. In September, 1976 he was nominated to serve on the State Health Coordinating Council (SHCC), a 67-member group, comprised of representatives from Ohio's 10 HSAs, as well as other health care providers and consumers. SHCC acts in an advisory capacity to the State Health Planning Development Agency (SHPDA).

Dr. Diller has been with the Council since the late '70s, serving on various committees and participating in their meetings. Late last year, he was elected the group's chairman.

"The job I have as chairman is largely an administrative function," he says, but he is quick to point out that the work done by SHCC is more than just token involvement.

"We study the matters carefully and listen to all sides before taking a stand," he says — and while SHPDA is not obliged to take the advice offered by its consulting agency, it is rare when they do not.

"Federal legislation has mandated stringent criteria for the Council's makeup," Dr. Diller says, and as a result, SHCC has an abundance of consumer representation. However, Dr. Diller does not look on that as being necessarily bad.

"The consumers with whom we have had contact on the Council are knowledgeable, informed, and concerned. Of course, they can't provide the kind of expertise we can in certain areas — that's why you need physician involvement — but they do present different views which need to be considered."

In fact, Dr. Diller says that he enjoys SHCC's "open forum" atmosphere where provider and consumer can communicate with each other on a citizen-to-citizen basis.

"The old stereotypes break down when we discuss business," he says.

But not all business at SHCC runs a smooth course. As with other government agencies, SHCC often gets bogged down in its own bureaucracy, and one of the criticisms of the system is that it has become more and more "process" oriented — paying more attention to the "hows" and "whys" of the plans rather than the ultimate results.

"We spent one recent meeting discussing how to count beds," Dr. Diller says, pointing out that this is the kind of bureaucratic nit-picking

Should physicians get involved?

that can ultimately destroy the system.

"We need to become more results-oriented. Perhaps in order to accomplish this, health planning should take place every three years instead of every year."

Dr. Diller also advocates taking health planning out of federal hands and returning it to a local "grass-roots" level.

"Health planning was being done locally long before the federal government got into it," he says, — but with Washington's sudden surge of interest in rising health care costs in 1976, the emphasis on health planning was shifted upward from the local to the federal level.

"Then, the state legislatures had to comply because the federal government was threatening to withhold badly needed monies if they didn't," Pennington noted.

So SHPDA, SHCC, and similar state agencies were born. But the question of whether or not federal or even state health planning agencies have affected any cost savings is still unanswered.

"In some cases, perhaps it has — but there's no doubt that bureaucracy costs money. The question has been asked, are we just trading dollars for dollars, or are we saving dollars?", Dr. Diller says.

That question may be moot now that Ronald Reagan has assumed the reins in Washington.

One of Reagan's stands during his presidential campaign was less federal intervention in areas such as medicine — and that's a campaign promise which the American Medical Association (AMA) expects to hold him to.

At the recent AMA interim business meeting held in San Francisco (see "The San Francisco Connection," the Ohio State Medical Journal, February 1981, for a complete report), the delegates adopted a resolution which supported immediate cessation of funding for health planning at the federal level, and in fact, called for the AMA to begin legislation which would repeal the federal health planning law, and return health planning to the local level.

Obviously, it's a resolution which Dr. Diller supports — and he notes

"Health planning was being done locally long before the federal government got into it."

— Alford C. Diller, M.D.



Alford C. Diller, M.D.

"Medical views should be espoused whenever and wherever there's an opportunity"

that there's already a change in attitude at the state level, now that Reagan is in office and the AMA has made its first move.

"Right now, the agencies are scrambling for justification," Pennington points out. "What we'll probably be seeing in the future is more decentralization of health planning. The agencies might also be defunded, gradually, which will do away with some of the bureaucracy."

But both Pennington and Dr. Diller agree that the basic structure of health planning is here to stay. In 1978, the OSMA House of Delegates realized this, too, and took a stand to work with the federal government to insure quality medical care.

"There is a need for health planning," Pennington says, "and physicians need to be involved."

"You just can't practice in a vacuum," Dr. Diller adds. "Physicians don't anticipate social changes the way the legislators can. The legislature perceived a need and they acted on it. That's their job, and that's what physicians are going to have to learn to deal with. But physicians are citizens, and as citizens, it's not only our right, but our responsibility to get involved in the system. There are broad issues at stake, and we can't let these issues be decided without adding our voice."

Physician involvement is, in fact, so important to Dr. Diller that he is sometimes questioned as to whether or not he has become "too involved."

"People ask me whether I have a 'conflict of interests' with all the roles I play." (In addition to his roles in health planning, Dr. Diller also serves as OSMA Councilor from the Third District.) "But I see no conflicts.

"As I see it, I have access in a number of ways to discuss concerns and understand issues. Medical views should be espoused whenever, and wherever there's an opportunity. Physicians tend to want to be isolationists. They don't want to get involved. But if you ignore the issues, you're cutting your own throat. The other side will win by default." OSMA

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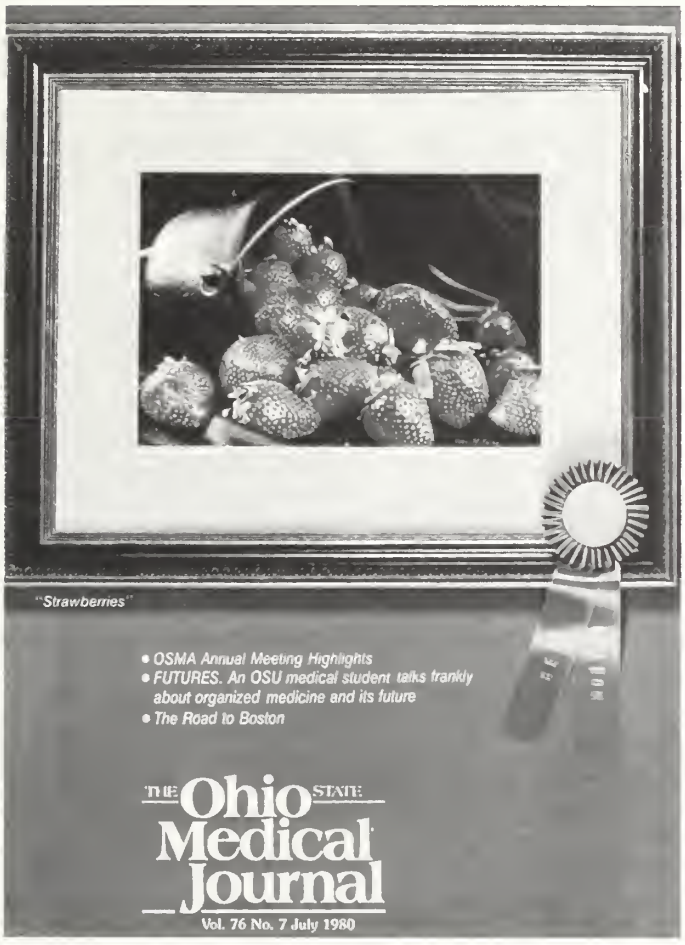
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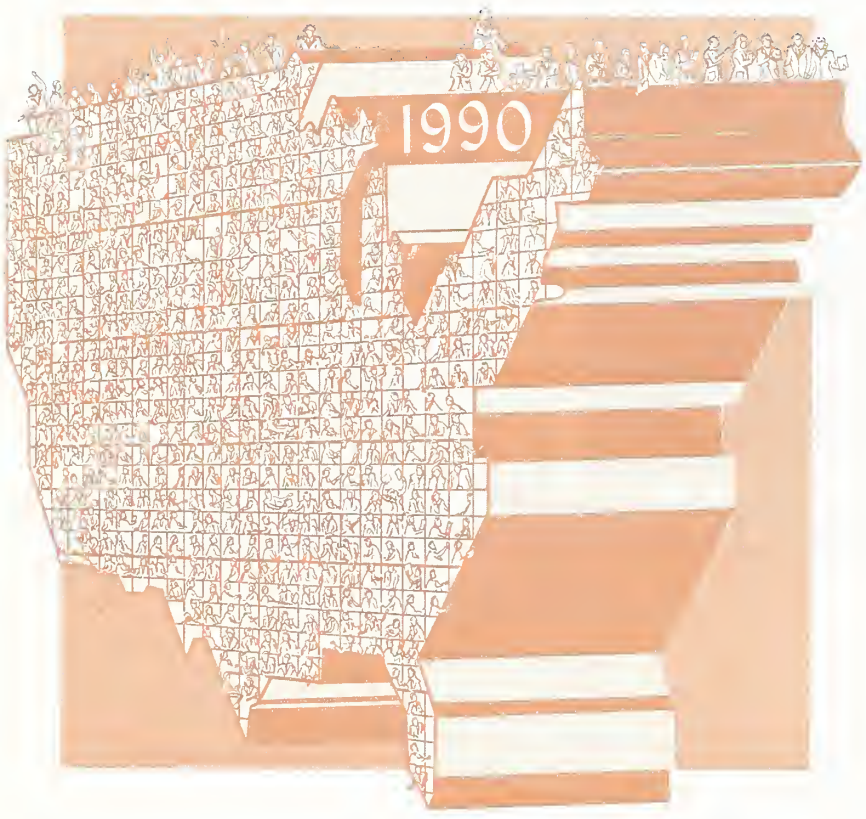
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The Road to GMENAC

By James E. Morgan, M.D.



The recent report by Graduate Medical Education National Advisory Committee (GMENAC) anticipating a marked oversupply of physicians by 1990, has attracted a great deal of attention and deserves thoughtful study. This is not the first time it has been felt that the medical profession in the United States was on the verge of being overcrowded. The following paragraph was published in 1936:

"Last year, 5,500 new physicians were licensed and thus added to the (medical) profession as contrasted to approximately 4,000 deaths in the profession that occurred that same year. These figures indicated that at least 1,500 have been added to the already crowded profession. If this rate of increase is allowed to continue, the overcrowding will become a greater menace both to the profession and the public. In order to prevent the overcrowding from becoming greater than it is at present, it will be necessary for the medical schools of the country to agree to reduce the total number of graduates. The practical solution would seem to be for the medical schools to reduce the number of students in their graduation classes by 5% each year for the next 5 years."

Sounding strangely like the GMENAC report, this is from an article entitled, "Overcrowding of the Medical Profession," published in the *Journal of the Association of Medical Colleges* by Dr. A. D. Bevan in 1936. Dr. Bevan was chairman of the

Dr. Morgan is the Coordinator of Medical Affairs at Deaconess Hospital in Cleveland, Ohio.

Committee on Medical Education of the American Medical Association (AMA) in 1902, and was influential in forming the Council on Medical Education of the AMA, which has continued to have great influence today. Dr. Bevan, therefore, had strong credentials behind him when making such a statement.

The medical literature through the 1930s is replete with similar articles warning that the medical profession was overcrowded and that further education of physicians must be limited. This attitude appears, from the perspective of 1980, to have been more influenced by the despair of the "depression days" than any serious study of health care needs. There were repeated statements that 50% of physicians were making only a meager living from the practice of medicine. In fact, in 1939, Philadelphia newspapers published the prevailing wages for occupations adopted by the Philadelphia County Assistance Board, and those studies peg physician income at the munificent sum of $1.51 per hour (see table).

With dismal economic facts such as these, it is understandable that some felt the solution to be limitation of the number of physicians. In 1937, reports showed that there had been a 12.5% decrease in the number of students admitted to medical schools in the past four years, and that this had been due largely to the inspection of medical schools by the American Medical Association, the Federation of State Medical Boards of the United States, and the Association of American Medical Colleges.

Thus, we see through the 1930s, a moratorium on the opening of new medical schools which was to last until 1965. By that time, the government realized that there was, and had been for some time, an acute shortage of physicians, and by various subsidies encouraged the building and opening of new medical schools. From the mid-1960s to 1976, the number of medical schools in the United States increased from 87 to 116, and the number of graduates per year increased from 7,336 to 13,607, an increase of 87%. The number should soon stabilize at about 17,000.

Recently, GMENAC, a government-sponsored plan of 21 experts, including 13 physicians, has issued a report prophesying an oversupply of physicians by 1990, amounting to 70,000 physicians. They recommend the cessation of medical school building and the limitation of numbers entering school by 5% each year until the situation is corrected — the same solution recommended by Dr. Bevan in 1936.

Thus, between 1936 and 1980, there has been a complete turn of the wheel. What happened and how was the supply of physicians maintained with no increase in the number of medical schools? After 1940, with the pick-up of the economy incident to and following the war, the demand for medical care and hence physicians, increased explosively. Part of this expansion was caused by the increased number of physicians going into research and teaching, and by the rapidly developing technologic areas. There was also a steady increase in the population.

The medical literature through the 1930s is replete with . . . articles warning that the medical profession was overcrowded and that further education of physicians must be limited.

Two important trends affected post war developments:

1. A **great increase in the number of residencies.** Many community hospitals developed teaching plans and received accreditation from the AMA as a teaching residency. With no increase in the number of American graduates, there were more residency slots open than there were people to fill them.

2. The **implementation of the student exchange program.** This program was essentially to issue temporary student exchange visas to students from less developed countries to allow them to come to this country to further their education. They were expected to return home to contribute to the development in their countries. With the opportunity to come to this country, an increasing number of Foreign Medical Graduates (FMGs) began to arrive. They had no trouble finding residency positions, particularly in the community hospital programs, and made valuable contributions to the care of patients, although many of them feel in retrospect that such service exceeded their educational opportunities. While the immigration laws changed from time to time, more FMGs were able to change their temporary visas to immigration visas and settle in this country permanently.

During these earlier years, there was very little, if any, control over the inflow of the FMGs. A certain number were admitted who were very poorly prepared to assume patient care and many had very little or no proficiency in the English language. During that time, very sketchy statistics were kept and it is practically impossible to identify how many came, went home, or remained.

In 1956, there was an important development in the organization and implementation of the Educational Council for Foreign Medical Graduates (ECFMG). This body was organized to develop a program of evaluation, examination, and certification of foreign educated physicians who desired to enter graduate medical education programs in this country. This began to bring order out of chaos. The ECFMG verified the credentials and conducted examinations in both medical subjects and proficiency in the English language to determine that FMGs were properly qualified to assume care of patients. These examinations were given not only in this country but throughout the world.

Soon ECFMG certification became mandatory before securing a residency in an approved program and also before taking the State Board examination in most states.

In 1965 there was another change in the immigration laws which recognized a shortage of physicians in this country and gave physicians preferential treatment when applying for immigrant visas. Many came as immigrants, even though they had not taken the examination. There was a marked increase in the number taking the ECFMG examination and in 1973, 1974, and 1975, the number exceeded 35,000 per year. In 1979, however, the number dropped to just under 20,000.

The cumulative numbers of those taking the examination from 1958 through July, 1979, are as follows:

No statistics are available currently on how many of those passing the examination came for residency education, or how many of those who came stayed as permanent immigrants. However, it is accepted that of the approximately 400,000 physicians in this country, about 91,000 are FMGs. This 91,000 is roughly half the number who took and passed the ECFMG examination since 1958. There is no direct correlation between these figures because many who passed the examination never came to this country. Many came, received their education, and returned, and many of the 91,000 were here before the ECFMG examinations were instituted.

How have the FMGs fit into the postgraduate education system and the health care delivery system? During the 1950s and 1960s there was what might be termed a two-tier residency system.

1. Residencies in university and university-affiliated teaching hospitals.
2. Residencies and teaching programs in community hospitals.

By and large, the residency slots in the university hospitals were filled by American graduates. These individuals tended to take long-term residencies and fellowships and remain in research, teaching, and practice affiliated with universities. The FMGs tended to fill the residency slots in the community-type hospitals and proceeded to practice at a community level. In this, they are fulfilling a vital function, and if many communities were suddenly deprived of their presence, the delivery of health care would collapse. Of course, these are generalizations and there were many crossover exceptions to prove the rule.

It seems, however, to be an established fact that without these 91,000 FMGs there would have been a serious shortage of physicians in this country, and that the recent increase in the number of medical schools and medical graduates was sorely needed. In fact, it seems somewhat ironic that the United States, the richest country in the world, has had to depend on less developed countries to educate one out of four of our physicians for the past 35 years.

Now, as has been mentioned, the GMENAC report advises a moratorium on building any more American medical schools and a decrease in the number of students allowed to matriculate. However, if the past as illustrated here is any indication of the future, then perhaps more careful consideration should be given before the number of American students starting medical schools is limited again. Otherwise, a 44-year-old cycle may begin all over again. OSMA

AUGUST, 1939

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Maternal Serum Alpha-Fetoprotein Testing

Editor's Note: At the recent interim meeting of the American Medical Association, the Council on Scientific Affairs presented its report on "Maternal Serum Alpha-Fetoprotein Screening." The report was adopted by the delegation with some amendments. The following article is a synopsis of that amended report.

INTRODUCTION

In January 1980, the Council on Scientific Affairs was presented a number of issues regarding maternal serum alpha-fetoprotein (AFP) testing in detection of open neural tube defects (spina bifida, cystica, encephalocele and anencephaly). The Council identified several scientific questions regarding the appropriate use of the test and discussed medicine's concern over the U. S. Food and Drug Administration's (FDA) announced intent to strictly regulate AFP testing.

The proposed FDA regulations are consistent with the 1979 report of the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) Alpha-Fetoprotein Task Force.

The Task Force guidelines involve limiting the use of alpha-fetoprotein test kits to a carefully monitored laboratory and physician-user system in order to gather more data on: (1) the incidence of elevated maternal serum alpha-fetoprotein levels in various populations in this country, and (2) the utilization of follow-up diagnostic techniques (and the incidence of spontaneously aborted pregnancies) when AFP test results are positive.

In the course of its deliberations concerning AFP testing — deliberations regarding the safety and effectiveness of the technology, as well as the impact of the imminent rules — the AMA Panel was primarily concerned with the scientific and medical questions regarding AFP screening. Nonetheless, the Panel felt that the scope of the proposed restrictions on the sale, distribution, and practitioner's use of the test reflects the FDA's intent to invoke the full measure of its authority to establish conditions of medical practice as a **quid pro quo** for approving the release of a controversial new medical device and technology.

ALPHA-FETOPROTEIN DETERMINATION

AFP is a glycoprotein that resembles albumin. It is made initially by the yolk sac and then by the fetal liver. The level of AFP in fetal serum rises rapidly through the 13th week, when it becomes the principal serum protein, and then declines steadily throughout the rest of gestation. It is normally excreted via the fetal urine into the amniotic fluid, whence it diffuses into the maternal serum.

Elevated levels in a nonpregnant adult indicate an abnormality. To date, this elevation has been associated with hepatic carcinoma, hepatoblastoma, nonseminomatous testicular tumors, yolk sac tumors of the ovary, and rarely other upper GI tract tumors.

In the pregnant female a certain degree of elevation is normal. However, when the level increases more than approximately 2.5 times the expected median, at 16-18 weeks, there exists a significant possibility of an open fetal neural tube defect (NTD), anencephaly, or spina bifida.

Other factors that may cause abnormal elevation of maternal serum levels in a normal pregnancy include: twinning,underestimation of gestational age, or laboratory error. In addition, amniotic fluid elevation may be caused by fetal blood contamination.

MULTISTAGE TESTING PROCEDURE

Because the predictive value of a positive test for a single maternal serum test only allows telling the patient that the probability of having a neural tube defect is 1 in 30, further testing needs to be carried out.

SONOGRAPHY

After the second positive serum test, sonography is recommended to corroborate gestational age (biparietal diameter and other sonographic techniques), exclude twins, evaluate the viability of the fetus and detect anencephaly. Approximately 50% of those who have a sonogram will be found to have other explanations for the maternal serum AFP elevation. Of this group 50% will have revised gestational age, 40% will have multiple pregnancies, 10% will have intrauterine fetal death. At the same time, 3% will have anencephalic fetuses.

At this stage, sonography will eliminate half of the women from the group at risk. However, because anencephalics constitute approximately 50% of open neural tube defects, only half of the open neural tube defects remain undetected. Therefore, the percentage of the at-risk group with fetal neural tube defects remains the same, as shown by the predictive value of a positive test (PVPT) holding at 5%.

AMNIOCENTESIS

In order to reach a large enough predictive value of positive test (PVPT) to be generally acceptable in determining whether to terminate pregnancy, an amniocentesis must be performed. Evaluation of the amniotic fluid requires a radioimmunoassay with a specificity of between .995 and

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.999 to obtain a predictive value of a positive test of 90% to 98%, respectively. This is obtainable with the presently used test kits.

Amniocentesis entails two types of risk. The first is the possible contamination of the amniotic fluid with fetal blood and the second is abortion or fetal loss attributable to amniocentesis. Because of the high levels of AFP in fetal serum, slight contamination of the samples can lead to erroneous test results. This requires that quality control measures on the part of the laboratory include a test for hemoglobin in the amniotic fluid.

Most studies have reported a fetal loss attributed to amniocentesis between 0.5% and 1.5%, although some have reported higher rates. If all pregnant women in the United States were screened by serum AFP testing, then every year amniocentesis would be recommended for 51,000 (1.7% of 3,000,000) women in order to detect 2,300 defective fetuses. If 1% is assumed for the unintended fetal loss associated with amniocentesis, then 51,000 amniocenteses would cause the loss of approximately 500 normal fetuses.

Although sonography should detect almost all anencephalics, survival of these fetuses is universally poor and the need for the screening program is not clear cut. The benefit in the case of fetuses with spina bifida is even less clear cut. How well detailed ultrasonography will be able to predict the severity of the impairment prior to the decision to continue with the pregnancy remains to be determined.

The unintended fetal loss is not the only negative consequence of AFP screening. The psychological stress that the patient with a false positive serum test must undergo, before the final outcome of sonography amniocentesis and abortion is known, is difficult to measure; but it should not be ignored. The proposed protocol would require that about 25 mothers would have to undergo this stress for every single neural tube defect aborted. The Panel questioned seriously whether the psychological burden of these patients, when added to the unintended fetal loss, is a fair trade-off for the benefits of such a screening program.

HIGH RISK PREGNANCIES

Patients may be placed in a "high risk" category because of previously affected children or parents. In the vast majority of cases there has been one previous child. There is a recurrence rate of 5% for the pregnant woman who has previously had a neural tube defect fetus. Therefore, the predictive value of a positive test for this group is 5% prior to any testing. Because of this, many investigators recommend starting the testing in this group with a sonogram guided amniocentesis.

ETHICAL AND LEGAL ISSUES

Finally, the rationing of medical care by the proposed mechanism raises many other questions. For the woman who might wish to interrupt a pregnancy that had one chance in 20 of being even mildly abnormal, is it fair to withhold a serum test if she is in the wrong medical catchment area or to make her continue on with the prolonged and expensive testing that the protocol demands when interruption of pregnancy could settle the issue? The AMA has maintained since 1974 that patients have a right "to be free of coercion in determining when they will submit to the performance of elective medical procedures such as sterilization and abortion." Such determination should be made with all the facts known, including the level of likelihood that an abnormal fetus may be present. Also, the legal liability on the physician in attendance when a neural tube defect fetus is delivered will weigh most heavily should he have refused to perform a requested maternal serum AFP test.

CONCLUSIONS AND RECOMMENDATIONS

After reviewing the ACOG/AAP Task Force work and other available data, the Panel agreed generally with the guidelines set out in the Task Force report. The use of alpha-fetoprotein testing as a screen for neural tube defects does require good coordination of multiple services. There is a need for high quality medical and laboratory work, timely genetic counseling, experienced personnel for follow-up testing, including sonography and amniocentesis, and for abortion services.

The Panel concluded that AFP screening of all pregnant women should not be advocated at this time. However, it stated that the individual physician should have the prerogative to employ the test in the course of counseling those high risk patients who have a previous familial history of neural tube defects and to use it in other selective populations where a high prevalence rate of the detectable defects is known to exist.

With regard to scientific questions, therefore, the Council on Scientific Affairs recommends that:

The AMA encourage the development of a carefully planned educational program on AFP testing and prenatal counseling for both physicians and patients. The creation of this educational program and the dissemination of related information should be undertaken in cooperation with other organizations of health care professionals, the leadership of appropriate consumer groups, the Food and Drug Administration and other appropriate governmental agencies.

The Reference Committee recommended that Report I of the Council on Scientific Affairs be adopted and that the following Substitute Resolution 35-A be adopted:

"RESOLVED, That the AMA actively oppose the Department of Health and Human Services current proposals to regulate the sale and use of AFP (alpha-fetaprotein) diagnostic kits, and be it further

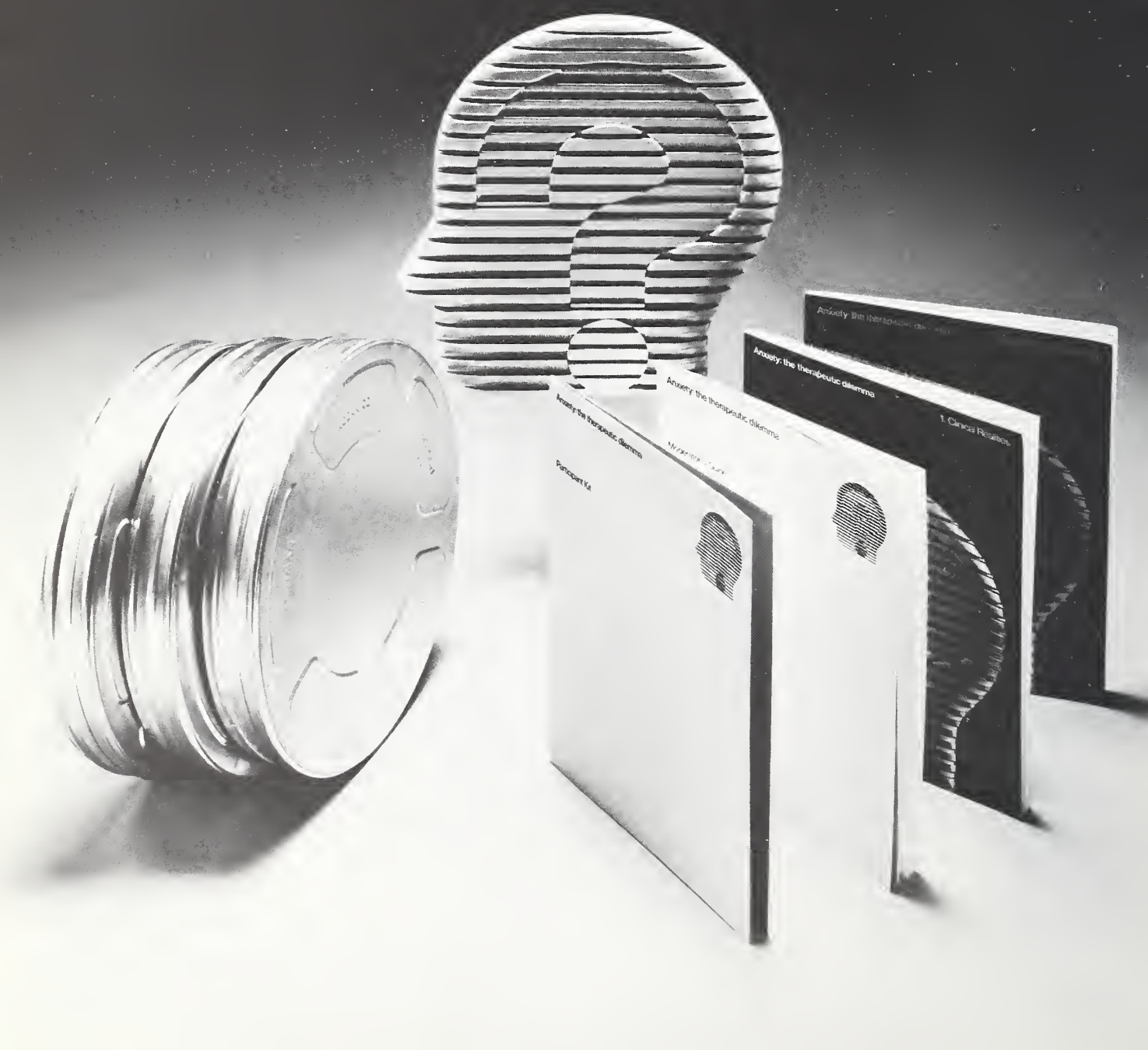
RESOLVED, That the legitimate concern for the safe and effective use of AFP in the complicated testing chain required for the identification of fetal neural tube defect be addressed as outlined in the Council on Scientific Affairs Report I, I-80; and therefore be it

RESOLVED, That the AMA reaffirm its objection to the use of the Medical Device Amendments of 1976 as a means of controlling the practice of medicine."

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Recently, in an attempt to establish a faster, more efficient method of claims processing, in cooperation with physicians the OMIM introduced an electronic claims filing system known as the Ohio Provider Entry Network (OPEN).

With OPEN, computer terminals are installed in physicians' offices where large numbers of Blue Shield claims normally are generated. Through the terminal, patient claims information can be transmitted directly to OMIM, thereby eliminating the need for a paper claim form. OPEN also can accept tape and diskette entry to accommodate more physicians and billing services.

OMIM uses other computer systems to assist in claims processing — for example "Automed," which automatically adjudicates 60-70 percent of all Medi-fill claims.

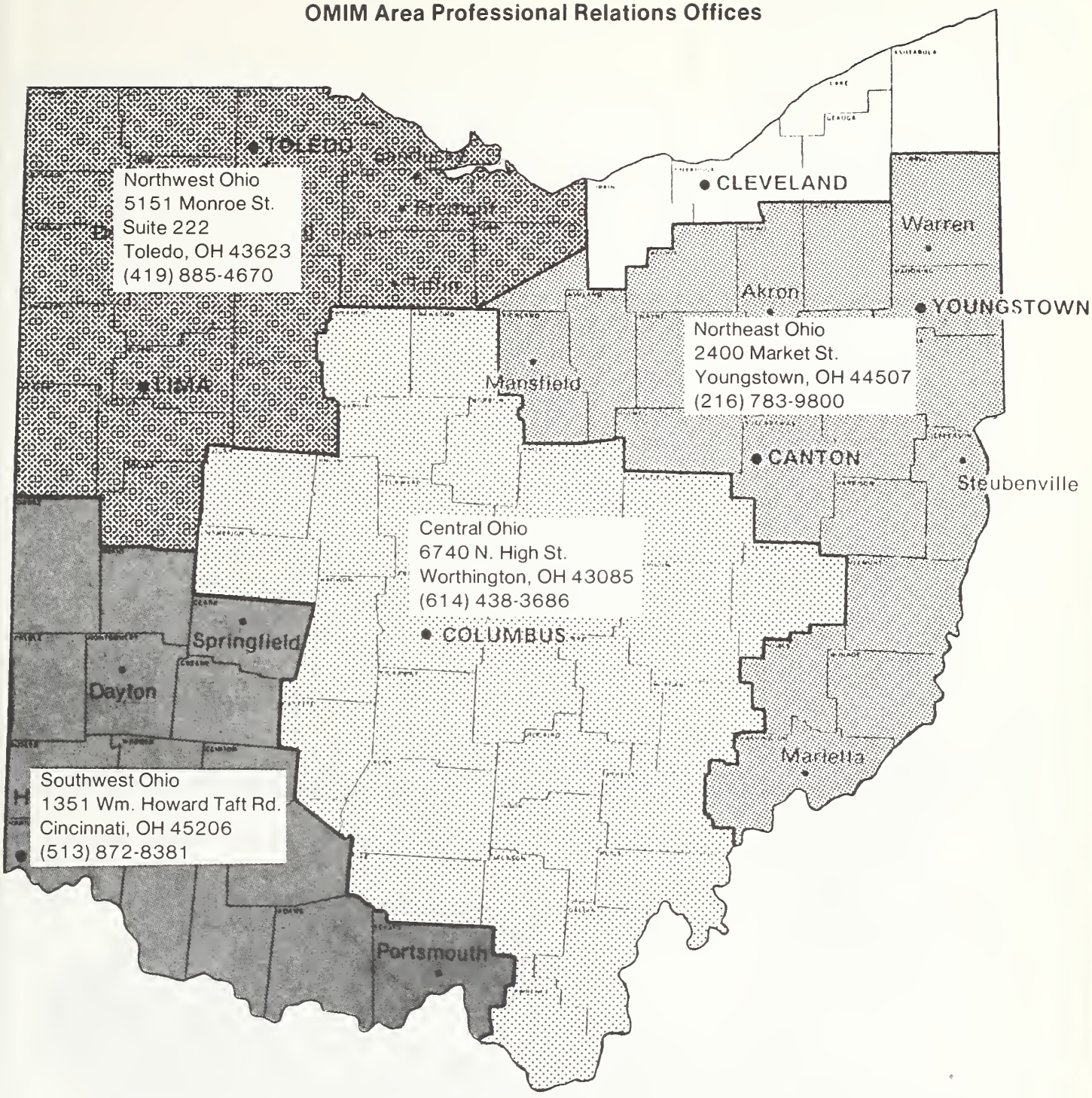
A new "reject voucher" program has also been designed to assist physicians with office records management. The voucher lists all services rendered to patients that were not payable under their Blue Shield contract. The reject voucher includes the patient's name and account number and the Blue Shield subscriber's name and contract number. Previously, services rejected for payment were listed on OMIM's payment voucher, and only if space was available. The new reject voucher will be mailed, in addition to the payment voucher, on all claims where the subscriber has authorized that payment be made directly to the physician. Major Medical, Medi-fill, Dental, Vision and Hearing contracts are not included in the program, however, rejected services for OMIM's basic medical/surgical coverages will be listed. The reject voucher program is expected to save time for the physician's office and make it easier to maintain accurate, current claims records for patients with Blue Shield coverage.

"In an attempt to establish a faster method of claims processing, OMIM introduced an electronic claims filing system."

Blue Shield Contracts

OMIM offers two basic contracts for physicians' services: UCR and

OMIM Area Professional Relations Offices



indemnity, or scheduled benefits.

Indemnity contracts share the cost of medical and surgical services with the patient and feature a schedule of payments with specific benefit limits for each covered service.

UCR contracts do not limit payments to a specific benefit amount. Instead, OMIM pays a physician's total charge for a covered service, provided that the charge is usual, customary, and reasonable (UCR).

UCR payment levels are calculated for each medical/surgical and dental procedure. The data base used to determine the appropriate payment includes all charges for all services by all providers. UCR ranges are computer-generated when a specified number of cases have been experienced.

UCR payment levels are regularly calculated and reviewed using current charge information. As new data is added, the oldest charge data is dropped from consideration.

UCR ranges are updated when charge patterns indicate that payment levels are no longer appropriate. Maximum payment levels are referred to as UCR, the UCR profile, customary maximums, or UCR ranges.

In addition to UCR and indemnity basic contracts, OMIM offers subscribers Major Medical coverage. Major Medical complements and

extends the protection provided by the basic contracts. The Medi-fill contract works in conjunction with Medicare to provide supplemental benefits for senior citizens. OMIM also provides coverage for dental, hearing and vision care services.

A new product which OMIM has recently begun to market to Ohio groups is HEALTH CHOICES — a program which is geared toward "keeping people well" rather than "getting people well again."

Through the use of a health status survey, the program identifies the health needs of a group and tailors seminars and activities to meet those specific needs.

Typical HEALTH CHOICES programs include fitness, nutrition, accident prevention, stress management, smoking cessation, hypertension, diabetes, alcoholism and risk factors in heart disease.

Health Education

OMIM is somewhat unique as a third-party carrier in its health education and promotion efforts.

Both OMIM and the other Blue Shield Plans use national advertising as well as various public educational events and displays to encourage healthier lifestyles and the prevention of illness, accident, and disease.

One example of this health education approach is the "Mr. Yuk program," which is sponsored by OMIM in cooperation with Children's Hospital in Columbus. The hospital has established the Central Ohio Poison Center, part of the National Poison Center Network, and has incorporated the "Mr. Yuk program" to strengthen its 21-year-old poison center.

Mr. Yuk is a 24-hour authority that provides information on poison prevention and what to do in case of suspected poisoning. OMIM's financial support of the program includes television and radio announcements, stickers for the home, a poison facts booklet, and a public speaking program.

Other OMIM health education and awareness efforts include exercise courses, health education booklets, the Olentangy Run, a nutrition program, and lifesaving programs.

Understanding the claims filing and claims payment process is important to physician and patient. Accurate claim filing generally results in fast and accurate claims payment by the third party.

Ohio Medical Indemnity Mutual Corporation (OMIM), processes an average of 18,000 medical and dental claims each workday. Nearly 200 claims examiners process between $1.1 million and $1.4 million in benefit

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payments each day for OMIM's 3.5 million subscribers.

The average "turnaround time" for a claim at OMIM — that is, the actual number of days a claim is at OMIM before a check or statement is processed — is 12 to 14 days. Some claims are processed within one week; others, particularly those with missing or incomplete information, can take several weeks to be properly processed.

The Blue Shield Plan has established a claims filing procedure to speed the efficient processing of the large volume of claims received each day.

Claims Filing Procedure

When a physician or other provider completes treatment, the services performed should be reported for benefit payment on either a Blue Shield or American Medical Association (AMA) claim form. These forms provide the maximum amount of needed information for examiners to properly calculate benefits. Use of other claim forms generally will result in a request to submit a Blue Shield or AMA claim form.

If any required data is missing, processing stops while the subscriber or medical office is contacted for the information. For this reason, it is important that the physician and patient complete the claim form in its entirety to speed processing time.

OMIM then processes the claim, determines benefit payments according to the subscriber's contract, and issues a payment check or explanation of benefits to the subscriber or physician, whomever the patient specifies on the claim form.

Physicians who prefer to receive payment directly from Blue Shield should make sure the patient understands the payment procedure and checks the authorization box on the claim form. If the patient does not check the payment authorization box, payment will be sent automatically to the subscriber to satisfy contractual obligations. (Major Medical contracts require that payment for those services always be made to the subscriber.)

Once the claim is processed, a comprehensive explanation of benefits is sent to the patient and physician, detailing the charges and payments made according the contract. Services rejected for payment also are listed on a space-available basis.

In addition, reject vouchers are sent to physicians on all claims where the subscriber has authorized payment be made directly to the physician. The voucher lists all services rendered to patients that were not payable under their Blue Shield contract; it also includes the patient's name and account number and the subscriber's name and contract number. Only rejected services for OMIM's Basic medical/surgical coverage are listed on the vouchers. Major Medical, Medi-fill, Dental, Vision and Hearing contracts are not included in the program at this time.

Common Claims Errors

Two recurring errors on claim forms that cause needless delays in processing are omission of the patient's age and year of birth, and the subscriber's contract or certificate number.

Without the patient's age and relationship to subscriber noted, examiners cannot determine patient eligibility under the Blue Shield contract. The subscriber's contract or certificate number is necessary to determine what coverage the patient has.

In addition to patient's age and subscriber's contract number, the following items are most often omitted or completed incorrectly on claim forms:

- physician's tax identification or Social Security number
- physician's signature or legible stamp
- subscriber s signature
- complete description and date of service
- diagnosis
- patient's correct name (nicknames are not acceptable)

Any special circumstances related to the services performed or additional information should be included on the back of the claim form, rather than stapled to it. Stapled attachments can be misplaced during preprocessing procedures. A separate claim form should be used for each patient receiving services.



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Hemorrhoids and other anorectal uses–TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witchhazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.
Vaginal Uses–Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
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Simplifying Claims Filing

To simplify procedures in medical offices, OMIM is encouraging use of the AMA's Current Procedural Terminology (CPT) Fourth Edition codes and International Classification of Diseases, 8th or 9th Revision, Clinical Modification (ICD9-CM or ICD8-CM) diagnostic codes.

Use of these codes will minimize the need for narrative descriptions and subsequent examiner interpretation.

Complex Claims

The majority of claims filed each day at OMIM are routine and processed within the 12-14 day average turnaround time. Unusual or complex claims can take longer.

Complex claims can receive as much as a four-tier review. First, the claims examiner looks at the claim; next, a senior examiner, with extensive experience in claims adjudication, reviews it. If there still is uncertainty about the appropriate benefit payment for a service, OMIM's professional medical consultants examine the claim. Most claims are processed by this point. However, if necessary, specialty consultants assist in reviewing the claim to accurately determine appropriate benefit payments.

Claim Questions

Subscribers with questions about claims payment can contact OMIM's Customer Service department in person, by mail, or telephone, for a review of the claim. Most subscriber inquiries are satisfactorily answered on first contact with the department.

Physicians with questions about claims, or any Blue Shield policy or procedure, are encouraged to contact one of OMIM's four area Professional Relations offices.

Professional Relations representatives can answer physician questions concerning claims processing, contract benefits, payment levels, UCR administration — or any Blue Shield program.

Staff members also are available to visit medical offices to instruct personnel in fast, accurate claims filing techniques.

Following are the addresses and telephone numbers of OMIM's area Professional Relations offices:

Central Ohio
6740 N. High St.
Worthington, OH 43085
(614) 438-3686

Southwest Ohio
1351 Wm. Howard Taft Rd.
Cincinnati, OH 45206
(513) 872-8381

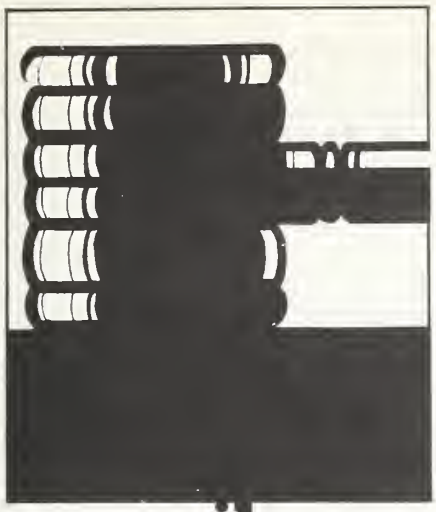
Northeast Ohio
2400 Market St.
Youngstown, OH 44507
(216) 783-9800

Northwest Ohio
5151 Monroe St., Suite 222
Toledo, OH 43623
(419) 885-4670

The Journal wishes to express its appreciation to OMIM staff members, Mr. Richard Glickler, Manager, Office of Provider Assistance; Mr. John Scaggs, Program Planner, Division of Medical Assistance; and Mr. Paul J. Richards, Director of Communications, for their help in assembling this article. OSMA

Fault finding

"If the AMA has faults, they are more the doing of nonparticipants who take what profession and society have to offer and return little. Yes, I wrote 'little.' Your practice is not enough. What are you returning of advice and interest to a country concerned by the escalating costs of your care, misled by politicians to believe government is the answer and the physician the villain? You say little, do nothing, and the responsibility for medicine's problems is right where it should be, at your feet." — Jerome K. Freedman, M.D., President, Connecticut State Medical Society, **Bulletin** of the Muscogee County Medical Society (January, 1980).



council proceedings

PROCEEDINGS OF THE COUNCIL

January 24, 1981

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, January 24, 1981, at the OSMA Headquarters Office, 600 South High Street, Columbus, Ohio.

Those present were: Robert G. Thomas, M.D., Elyria; Stewart B. Dunsker, M.D., Cincinnati; Thomas W. Morgan, M.D., Gallipolis; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; William Dorner, Jr., M.D., Akron; John H. Ackerman, M.D., Columbus; James E. Pohlman, Esq., Columbus; Thomas C. Coady, Esq., Columbus; and Terrance M. Miller, Esq., Columbus.

Those present from the OSMA staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Robert E. Holcomb; Gail E. Dodson; Richard A. Ayish; Rebecca J. Doll; Carol W. Mullinax; David W. Pennington; Eric Burkland; Michael L. Bateson; Jennifer M. O'Brien; and Gina Cummins.

ANNOUNCEMENTS BY PRESIDENT THOMAS

Dr. Thomas announced his approval of the reappointment of Dr. Frank E. Foss, Toledo, to the Ohio Board of Regents Paramedic Advisory Committee. He also announced the appointment of Dr. Leonard K. Smith, Kenton, to the Nurse Liaison Committee of the OSMA and Ohio Nurses Association.

ADMINISTRATION DEPARTMENT

The minutes of the December 13, 1980 meeting of the Council were **approved.**

The minutes of the meeting of the Council, held by conference telephone call, December 30, 1980 were **approved.**

Executive Director's Report — Mr. Page introduced Gina Cummins, new staff writer for the Communications Department, and announced the employment of Louis N. Saslaw as a member of the executive staff.

Resolution Distributed — A resolution from the Ohio Orthopaedic Society to the OSMA House of Delegates, regarding specialty society representation to the Ohio State Medical Association House of Delegates, was distributed for information.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Auditing and Appropriations Committee — Dr. Ford reviewed the minutes of the January 23, 1981 meeting of the Committee on Auditing and Appropriations.

The Committee recommended the formation of the 622 South High Street Corporation, a wholly owned subsidiary of OSMA. The capitalization of the new corporation and the financing and leasing structure of the corporation will be decided by the Council. The recommendation was **approved.**

The Council delegated to Dr. Thomas the selection of the initial directors to serve on the Board of the new corporation.

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Floor layouts for remodeling of the board room and the meeting room of the OSMA building were presented and **were approved.**

The Council requested that the staff investigate purchase and lease options for upgrading of the OSMA telephone system.

The Council set a high priority for developing the tape-to-tape data entry system to assist in welfare claim processing.

The Council **approved** a recommendation of the Committee that in answer to a request from the OSMA Auxiliary, $525 be allocated to assist two of the Auxiliary leadership in meeting expense of attending the AMA Leadership Conference.

(Dr. Yut dissented.)

The minutes as a whole **were approved.**

Committee on Membership — Dr. Morgan presented the January 14, 1981, recommendations of the Committee on Membership:

"That a letter along with the appropriate County Medical Society application form be sent to each resident offering 1) a free voting membership in the County Medical Society if available, 2) a free voting membership in Ohio State Medical Association and the American Medical Association. The free membership in the County Medical Society is contingent upon the county medical society dues for residents being no more than $10.00 and that a one-time $5.00 processing charge be paid by the residents which is to be retained by the county society."

The President and the Chairman and members of the Membership Committee and Department were commended by the Council on the membership program.

The report was filed.

Membership Statistics — Mrs. Wisse reviewed the membership statistics.

DEPARTMENT OF EDUCATION AND MEETING MANAGEMENT

Mrs. Dodson reviewed annual meeting plans. The Council voted to discontinue the scientific exhibits at the 1981 meeting.

The Council voted to cooperate with ACCME (Accreditation Council for Continuing Medical Education), the new committee at the national level for the accrediting of continuing medical education.

DEPARTMENT OF GOVERNMENT MEDICAL CARE

Health Planning Update — Mr. Pennington reviewed health planning.

Committee on Government Relations — Mr. Gillen presented the January 14, 1981 minutes of the Committee on Government Medical Care Programs.

The following recommendations were presented and **were approved:**

Increased funding be sought in the State of Ohio Biennial budget for reimbursement for physician services under Medicaid.

Staff explore with other state medical associations and specialty societies the interest and feasibility of tax credit incentives (both state and federal) for physicians who treat Medicaid recipients.

Staff investigate the feasibility of mandating that physician reimbursement under the Medicaid program be tied to a specific period of time (ie, 30 days).

The minutes as a whole were filed.

DEPARTMENT OF ORGANIZATION SERVICES

Ohio's AMA Delegation — Mr. Campbell reported on the activities of Ohio's AMA Delegation.

He announced March 6, 1981 as the annual meeting of the delegation with the Council.

An inquiry regarding support for Dr. Felino V. Barnes for several AMA positions was referred to the Ohio Delegation to the AMA.

PICO — Mr. Campbell reported on recent developments at PICO.

DEPARTMENT OF HEALTH EDUCATION

Mr. Clinger distributed the program of the forthcoming "Mid-Eastern Regional Conference of the Impaired Professionals" March 14-15, 1981.

With regard to a request of the Ohio Nurses Association that OSMA be represented on an ONA conference program on "Collaborative Practice" in October, 1981, the Council **approved,** with an amendment, that the officers of the Association approve the OSMA spokesman.

(Drs. Abromowitz, Ford and Yut dissenting.)

He announced the resignation of Dr. Timothy Moritz as Director of the Department of Mental Health.

The Council voted to express its concern to the Governor that a properly qualified physician professional be selected to replace Dr. Moritz as Director of the Department of Mental Health and that the President and the Executive Director call on the Governor to express these concerns.

DEPARTMENT OF STATE AND FEDERAL LEGISLATION

Mr. Ayish reported on state legislation. He submitted information on 16 bills involving medicine which will be considered by the Committee on State Legislation.

He also reported on cooperation with the Ohio Academy of Family Physicians in that organization's legislative activities.

Mr. Mulgrew reported on legislative developments at the federal level.

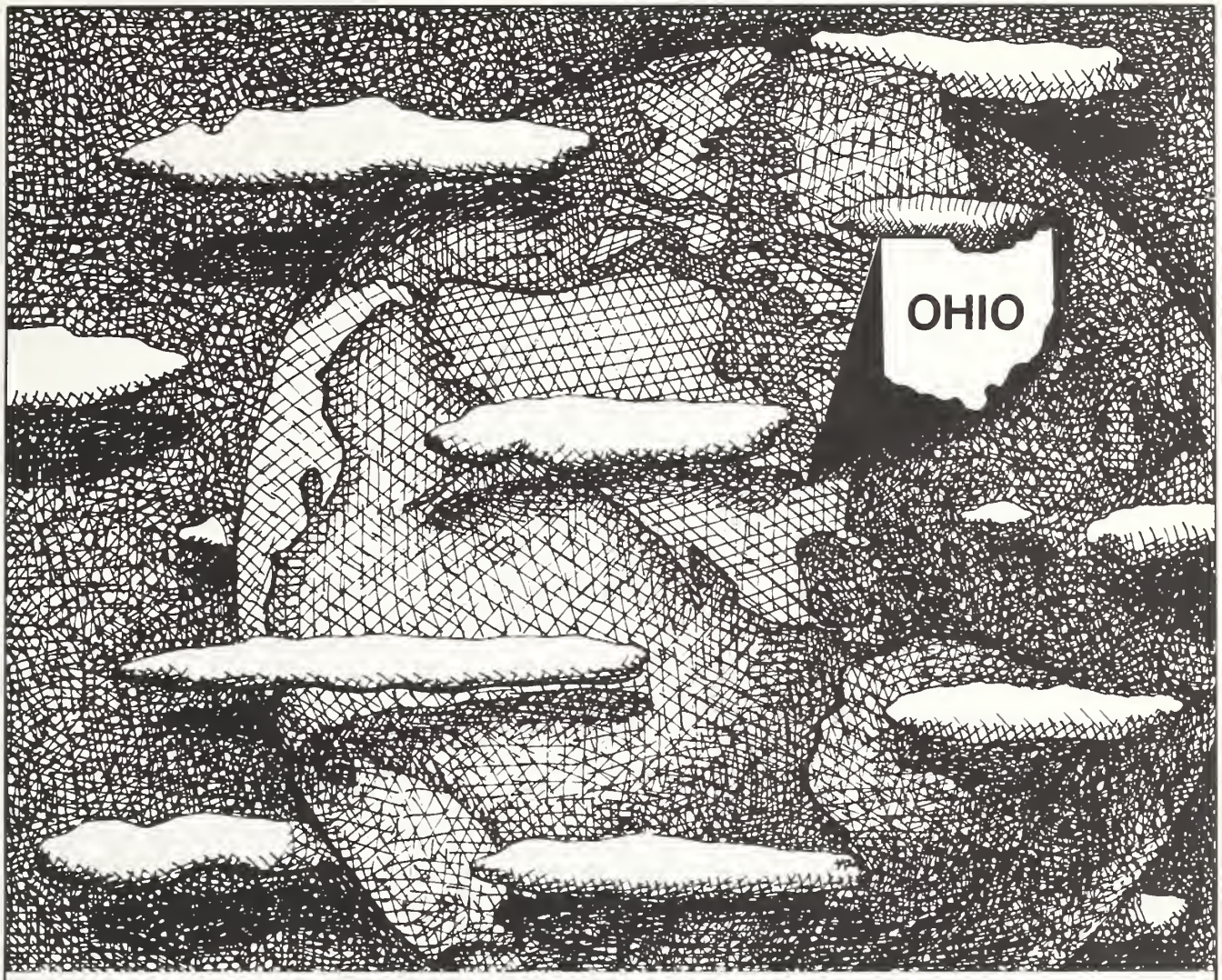
He announced that Congressman Donald J. Pease has been appointed to the House Ways and Means Committee and that Congressman Tony P. Hall has been appointed to the House Rules Committee.

Jail Project — Mr. Bateson reported that response from jails in Ohio has been good with eight new institutions seeking accreditation and four asking reaccreditation.

Committee on Organization Structure — Dr. Dunsker reviewed the January 23, 1981 meeting of the Committee on Organization Structure.

The Committee recommended that the Association expand communications with the medical school deans and the Council **approved.**

A proposal for an information manual for Councilors received the **approval** of the Council. Also **approved** was a recommendation that committees, including the Committee on Auditing and Appropriations, be requested to hold meetings at least three weeks prior to each Council meeting.



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Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

DEPARTMENT OF COMMUNICATIONS

Ms. Doll reported on special issues of **The Ohio State Medical Journal** for the remainder of 1981.

She announced that local advertising has almost doubled this year.

Four public service announcements were mailed the week of January 24, to all Ohio television stations by the department.

Ms. Doll said that the department is planning media seminars for medical reporters later in the year.

Presented to the Council was an update on the Marketing/Competition Research Study being conducted by the Communications Department.

The Council endorsed the concept as presented and asked that the department proceed with the proposal.

The Council voted to transmit concerns to the Communications Committee and to ask that the committee advise the Council of the committee's involvement in the marketing/competition proposal.

Ms. Mullinax announced that Gina Cummins will be writing for both the **Journal** and **Synergy.**

FIELD SERVICE DEPARTMENT

Mr. Holcomb reported for the Ad Hoc Committee on Highland District Hospital.

A request that the Ad Hoc Committee be a participant in a seminar on hospital/medical staff relations, to be conducted by the American Medical Association in Highland County at the hospital's request, was authorized.

(Dr. Yut dissenting.)

COUNCILOR REPORTS

The Councilors reported on the activities in their respective districts.

A communication from the Mercer County Medical Society was read by Dr. Diller, raising a question with regard to categorization of hospitals. Since "categorization" and "regionalization" are both on the agenda for the March 7 Council meeting, the Councilors were encouraged to obtain all the information possible from their counties with regard to problems arising and physician opinion on these matters.

Complaint Procedures — The process of handling complaints was referred to legal counsel for review and report back at the March 7 Council meeting.

CONSTITUTION AND BYLAWS

The Council **approved** proposed amendments to the Constitution and Bylaws of the Stark County Medical Society.

LEGAL COUNSEL REPORT

The Incentive & Disincentive Program being administered by Blue Cross of S.W. Ohio was discussed. The Council voted to establish an Ad Hoc Committee of the Council to work with legal counsel in determining the appropriate legal response by the association to the Incentive & Disincentive Program.

(Dr. Abromowitz, Chairman; Drs. Yut, Kilroy and Dunsker.)

The Council requested that the Ad Hoc Committee explore the matter in depth and report back to the Council.

The President was authorized to ask the Professional Liability Task Force to meet and formulate a recommendation to Council as to whether the mandatory arbitration provisions of H.B. 682 should be retained.

DEPARTMENT OF HEALTH

Dr. John Ackerman, Ohio Director of Health, addressed the Council.

He announced Dr. James F. Quilty, Jr., of Columbus, as the new chief of the Department of Maternal & Child Health.

On state health budget matters, he said that the Tuberculosis Subsidy Fund is entirely eliminated; that most of the arthritis funds are cut; and that alcohol funds are depleted.

He predicted that if the budget situation does not improve, ten to twelve percent personnel cuts will be necessary in his department.

ADJOURNMENT

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

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Physician interviews are currently in progress. For further details and consideration, please contact Neal Shannon collect at 614-457-9761 or send your credentials in confidence to Spectrum Emergency Care, Inc., Whetstone Medical Center, 3720-B Olentangy River Road, Columbus, Ohio 43214.



April

REGIONAL SEMINARS IN PSYCHIATRY — 1. DEPRESSION: April 22; Cleveland Metropolitan General Hospital; sponsor: Cleveland Metropolitan General Hospital; cosponsor: Case Western Reserve University School of Medicine; 7 credit hours; fee: $75, $35 students or physicians-in-training; contact: D. S. Schubert, M.D., Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland 44109, phone: 216/459-4428.

ANNUAL CANCER SYMPOSIUM: April 9-10; Medical College of Ohio, Toledo; sponsor: Medical College of Ohio; cosponsor: American Cancer Society, Ohio Division; 14 credit hours; fee: $90, $40 for students or physicians-in-training; contact: Howard S. Madigan, M.D., Medical College of Ohio, C. S. 10008, Toledo 43699, phone: 419/381-4237.

PREVENTION AND RECOGNITION OF ATHLETIC INJURIES: April 29; Sheraton Dayton Hotel, Dayton; sponsor: Wright State University School of Medicine; 7 credit hours; fee: $50; contact: David Shon, A.T.C., Dept. of Intercollegiate Athletics, Wright State University, Dayton 45435, phone: 513/873-2771.

May

CREATIVE FAMILY LIVING: May 1-3; Sawmill Creek Lodge, Huron; sponsor: Ohio Academy of Family Physicians; 10 credit hours; fee: $60 AAFP members, $40 residents, $85 nonmembers; contact: Mrs. Florence I. Landis, 4075 N. High Street, Columbus 43214, phone: 614/267-7867.

CONTROVERSIES IN NEW IMAGING TECHNIQUES IN DIAGNOSTIC RADIOLOGY: May 7-8; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $200, $100 physicians-in-training; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

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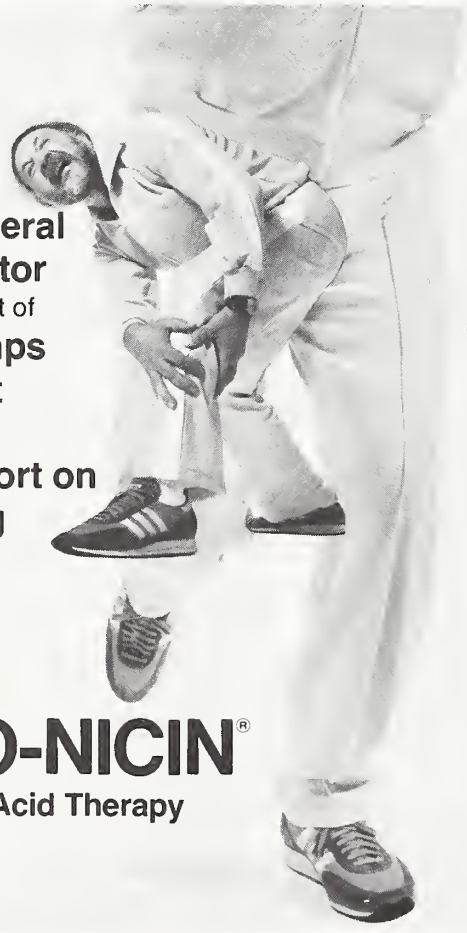
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BURR N. CARTER, M.D., Cincinnati; University of Virginia School of Medicine, Charlottesville, 1919; age 86; died December 8; member OSMA and AMA.

LOUIS N. JENTGEN, M.D., Columbus; Ohio State University College of Medicine, 1925; age 83; died December 10; member OSMA and AMA.

ZOLTON L. KLEIN, M.D., Chapel Hill, North Carolina; Case Western Reserve University School of Medicine, 1936; age 67; died November 28; member OSMA.

ANDREW McDONALD, M.D., Athens; Case Western Reserve University School of Medicine, 1941; age 65; died December 13; member OSMA.

NOAH MILLER, M.D., Akron; McGill University Faculty of Medicine, Montreal, Quebec, 1926; age 78; died December 6; member OSMA and AMA.

WILLIAM E. PFAADT, M.D. Coshocton; Ohio State University College of Medicine, 1942; age 62; died November 24; member OSMA and AMA.

MARGARET PRIBRAM, M.D., Cleveland; Justus-Liebig University Giessen, Germany, West, 1923; age 83; died December 3; member OSMA.

ARTHUR SCHUMACHER, M.D., Hilton-Head Island, South Carolina; University of Illinois College of Medicine, Chicago, 1934; age 73; died November 20.

WILLIAM SINGLETON, M.D., Portsmouth: Jefferson Medical College, Thomas Jefferson University, Philadelphia, 1921; age 87; died November 28; member OSMA and AMA.

HOWARD PEPPEL, M.D., McMurray, Pennsylvania; University of Pittsburgh School of Medicine, 1940; age 66; died December 10: member OSMA and AMA.

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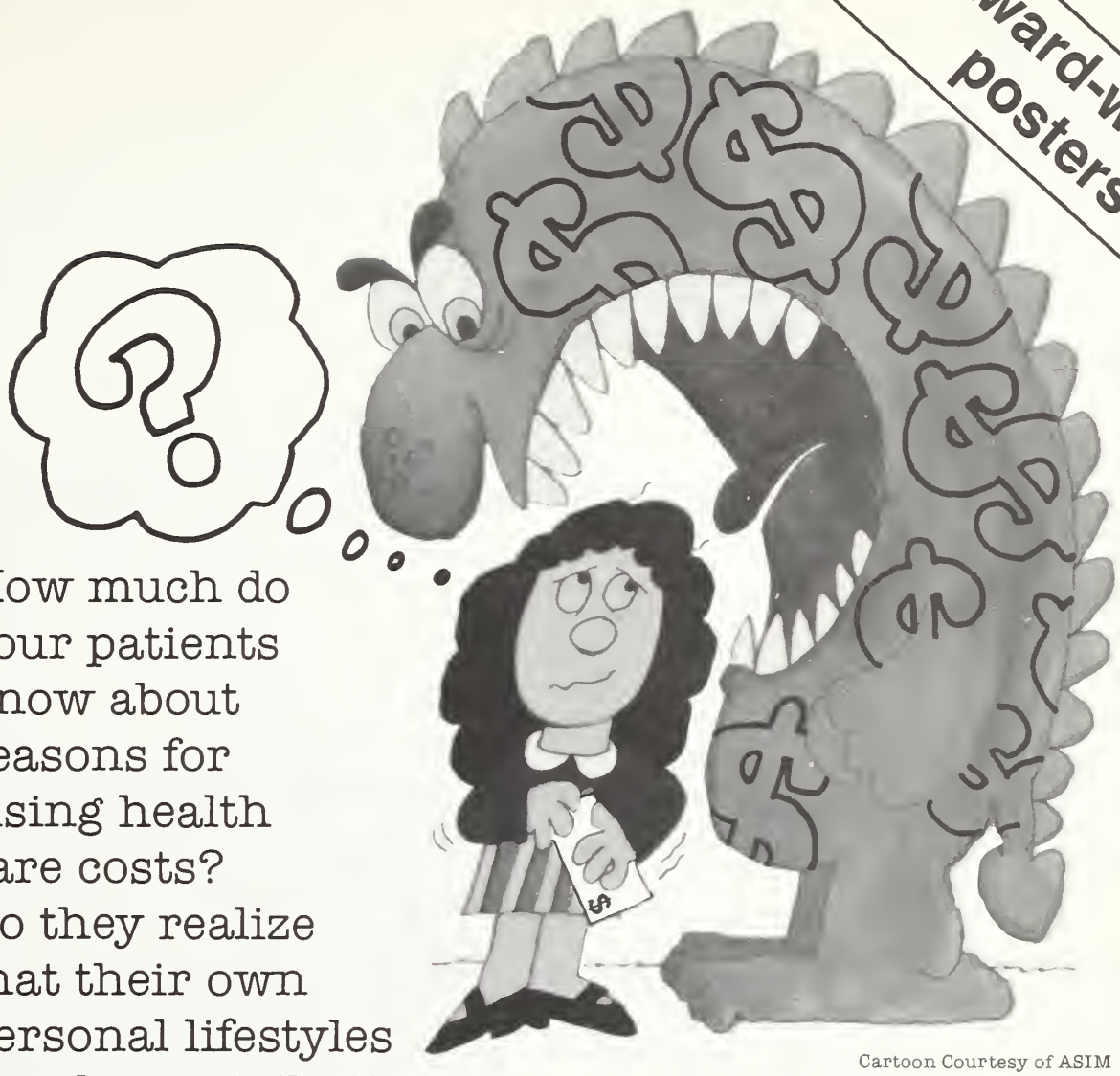
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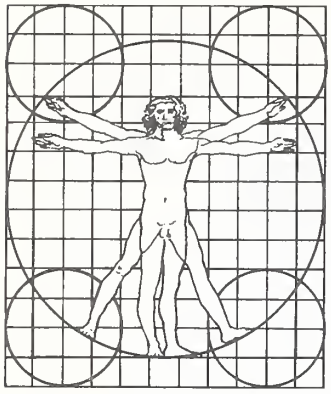
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CLINICAL & SCIENTIFIC

AN UPDATE ON ISCHEMIC CEREBROVASCULAR DISEASE AND STROKE

Anthony J. Furlan, M.D.
John R. Little, M.D.

Various stroke risk factors and methods of prevention are discussed herein.

ALTHOUGH RECENT EPIDEMIOLOGIC data suggests that the incidence of stroke is declining,[1] 500,000 Americans still suffer strokes each year. Cerebral infarction accounts for 80% of all strokes, the remaining 20% being divided between intracerebral and subarachnoid hemorrhage.

Effective stroke prevention now is possible through the early recognition and treatment of stroke risk factors. The major stroke risk factors are age, hypertension, coronary artery disease, and transient ischemic attacks (TIA).[2] The incidence of stroke approximately doubles with each decade increase in age.

Hypertension alone increases the risk of stroke at least four times over the expected rate. There is no absolutely "safe" level of blood pressure and even mild levels of high blood pressure should be treated, including isolated systolic hypertension.

Clinical or laboratory evidence of heart disease greatly increases the risk of stroke. Furthermore, the most common cause of death among stroke survivors is myocardial infarction, so that the detection of coronary artery disease plays an important role in the management of the potential stroke victim.

TIA is an episode of *focal* neurologic dysfunction usually lasting 2 to 15 minutes but sometimes as long as 24 hours. Certain symptoms such as lightheadedness, syncope, vertigo, or dysarthria appearing in isolation, should not be labeled TIA.

TIA increases the risk of stroke 16 times in some age groups. Among patients with TIA who do not die of a cause other than stroke, approximately one third will suffer a stroke within five years. More than 20% of these strokes will occur within one month of the initial TIA, and 50% will occur within one year after the first TIA.[3]

Many TIAs are related to atherosclerotic disease in the carotid or vertebrobasilar arterial systems. However, other causes of TIA or TIA-like symptoms must be excluded in every patient. Embolic sources, especially the heart, must be evaluated carefully. Cerebral mass lesions, migraine, focal seizures, and labyrinthine disorders all may produce symptoms mimicking TIA.

The management of atheroembolic TIA depends on several variables including the patient's symptoms, his overall medical condition, and the availability of a skilled angiographer and surgeon. With few exceptions, patients with vertebrobasilar TIA are managed medically either with antiplatelet or anticoagulant therapy. Cerebral angiography with visualization of both the extracranial and intracranial vasculature usually is performed in patients with carotid TIA who are in good medical condition.

Noninvasive tests, including the new digital subtraction angiogram, should not be used to make decisions regarding the need for selective angiography or the type of treatment in patients with typical carotid TIA.[4]

The information obtained from noninvasive tests, especially those which do not directly visualize the carotid bifurcation such as oculoplethysmography or directional Doppler also should be interpreted cautiously in patients with asymptomatic bruits or symptoms atypical for cerebral ischemia. Experience has shown wide variability in the false positive and false negative rates among different centers using these technics.

The findings on cerebral angiography are a major factor in deciding whether a patient with carotid TIA is a candidate for

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Submitted April 7, 1980.

endarterectomy or extracranial-intracranial arterial anastomosis. The best results of carotid endarterectomy have been in patients with atherosclerotic stenosis of the internal carotid artery on the side appropriate for the patient's symptoms.

Carotid endarterectomy has not been shown to reduce the risk of infarction in symptomatic areas of brain supplied by the vertebrobasilar system or the contralateral carotid artery. Generally accepted angiographic criteria for carotid endarterectomy are luminal narrowing of 60% or more, deep ulceration which is unlikely to heal with medical therapy, and/or the presence of a soft intraluminal thrombus.

The risk of carotid endarterectomy has decreased considerably over the past 20 years. This is related partly to the use of improved intraoperative monitoring technics such as electroencephalography and regional cerebral blood flow measurement. In institutions where carotid endarterectomy is performed frequently, the combined surgical morbidity and mortality rate has been reduced to 2% or less for good risk patients.

In patients with recent myocardial infarction, unstable angina, chronic lung disease, or an unstable neurologic course, the risk of carotid endarterectomy may be 7% or higher even in the best of hands.[5,6] Follow-up studies have suggested that the risk of cerebral infarction in properly selected patients who successfully undergo carotid endarterectomy approaches the expected stroke rate in the general population.

Surgical anastomosis between the superficial temporal artery (STA) and middle cerebral artery (MCA) for cerebral ischemia initially was performed by Donaghy and Yasargil in 1967.[7,8] Since then increasing numbers of patients have undergone cerebral revascularization procedures.

Candidates for an STA/MCA anastomosis may present with TIA or a small stroke in the territory of the carotid artery, but on cerebral angiography are found to have an inaccessible stenosis or occlusion of the internal carotid artery or MCA.

The symptoms in this group of patients are thought to reflect brain hypoperfusion and probably do not occur on an embolic basis. The assessment of regional cerebral blood flow (rCBF) is therefore an important component in the evaluation of patients who are potential candidates for STA/MCA anastomosis.

rCBF is determined from analysis of clearance curves following the intracarotid injection or inhalation of a diffusible isotope such as xenon.[9]

The use of double photon-emitting isotopes and the development of more sophisticated detection systems, for example, positron emission tomography, soon may allow the accurate topographic measurement of rCBF in cross sectional areas of the brain.

The risks of STA/MCA anastomosis have not been defined clearly but initial reports suggest that the combined morbidity and mortality of the procedure are similar to carotid endarterectomy. The effectiveness of cerebral revascularization in preventing brain infarction has yet to be established.

An international cooperative study supported by the National Institutes of Health currently is being conducted to help evaluate the efficacy of the procedure. Initial clinical experience suggests that STA/MCA anastomosis lowers the risk of stroke in selected patients with cerebral ischemia.

In patients not selected for cerebrovascular surgery, medical treatment is instituted. Contributory risk factors for stroke are treated, and most patients are placed on either anticoagulant or antiplatelet therapy. Anticoagulant therapy (warfarin) may decrease the risk of stroke in patients with carotid or well-defined vertebrobasilar TIA, but primarily in the first few months after onset.

Warfarin therapy usually is considered only in patients with recent onset TIA in whom no contraindications (severe hypertension, peptic ulcer) exist. Warfarin should be employed for only a three-month period following the onset of TIA.[10]

Recent evidence suggests that antiplatelet therapy with aspirin decreases the risk of stroke in men with TIA.[11] There is no evidence that other antiplatelet agents such as sulfinpyrazone (Anturane®) or dipyridamole (Persantine®) are effective in preventing stroke in patients with TIA.

It should be emphasized that aspirin is of no proven benefit as a stroke prophylaxis in women with TIA. Buffered aspirin, 650 mg b.i.d., commonly is employed to avoid gastrointestinal upset, but aspirin substitutes such as acetaminophen are ineffective.

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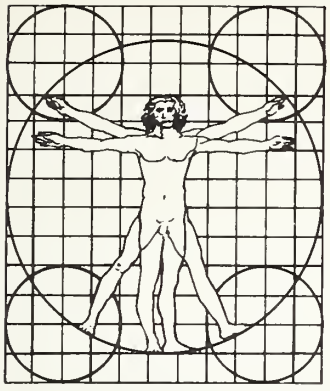
*PATIENT CARE Magazine—Outlook 1977 "Face-Off: Cost Containment vs. Chaos," January 1, 1977.

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CLINICAL & SCIENTIFIC

THE HEME-OCCULT PROGRAM IN NORTHWEST OHIO

Donald Steinberg, M.D., F.A.C.S.
Janet A. Steinberg, R.N.

The Heme-Occult Program in Northwestern Ohio is a community surveillance program to identify people who may be at risk of lower gastrointestinal tract disease. On preliminary analysis, it appears that we are identifying colorectal cancer at two to three times the usual rate of colorectal cancer detection and at an earlier stage of progression of the carcinoma.

THE HEME-OCCULT PROGRAM in Northwest Ohio is a comprehensive program of community surveillance of diseases of the lower gastrointestinal tract. Test packets are available at all pharmacies in the Toledo area and at public education programs for clubs, organizations, business, and industry.

Individuals determined to be at risk are those with occult or visible blood in their stools and these individuals are referred to their designated physician for further investigation. The gastrointestinal tract should not bleed and if there is bleeding, regardless of whether it is visible or detected by chemical means, every effort should be made to ascertain the cause so that proper treatment can ensue.

Among the many approaches for treating people with cancer, early detection of internal cancer offers the best chance of cure. This early detection is dependent upon two criteria. The first is that the pathogenesis of the cancer offer an expectation that significantly improved survival can be attained by early detection. The second is that the procedure available be economical and of good quality for community surveillance.

For example, the Pap test for cervical cancer is a simple procedure which has been widely accepted and has shown excellent results. The pathogenesis of cancer of the lung, however, is one which does not fulfill this criteria nor does its procedure for early detection (roentgenogram). Early detection of breast cancer through self-examination may be feasible, but the detection methods are relatively expensive. Colon cancer has an economical procedure for community surveillance and has a pathogenesis that offers an expectation that can be fulfilled.

At the present time there is a steady state of two cancers per thousand people over 50 years of age who develop colorectal cancer in any year. Thus, there were 110,000 colorectal cancers diagnosed in the past year in the United States. This rate has increased by about 10% from previous statistical surveys. Approximately 1 patient in 20, regardless of sex, will develop cancer of the colon some time in their lifetime, and with the present means of therapy and detection fewer than 50% will survive more than five years.

In addition, a large segment of the population do not seek medical care, yet we still must feel a responsibility for them. For example, during my 30 years as a surgeon, I rarely remember a cancer of the descending colon that did not come to diagnosis as an emergency with either complete or almost complete obstruction of the colon.

We know from the pathogenesis of the tumor that obstruction takes approximately two years to develop. We can take little pride in diagnosing a disease that has insidiously threatened the life of the patient for this period of time, nor can we excuse ourselves by declaring that he did not seek medical assistance. In contrast, an asymptomatic person with a positive Hemoccult is probably 80% curable.

There are a variety of approaches to the cancer patient, and I would like to be somewhat critical of these approaches, if only for emphasis. Education of the public and physicians has a limited value through the distribution of printed material and the formation of meetings for instructions.

As far as the tumor registries are concerned, once the tumor registry has been established, (for example, 10,000 of one particular type of cancer) little further value can be obtained from the cancer registry unless there is a specific new objective to be analyzed. All the work that was done prior to ten years ago for developing a cure for cancer is probably of little or no value since our understanding of molecular biology is in its infancy.

Dr. Steinberg, Toledo, Director, Heme-Occult Program; Director, General Surgery, Riverside Hospital; and Clinical Associate Professor Surgery, Medical College of Ohio at Toledo.
Ms. Steinberg, Toledo, Coordinator, Heme-Occult Program, Riverside Hospital.
Submitted August 18, 1980.

It appears that most medical investigations lacked the knowledge of the biochemistry of cellular reactions.

Therapy after metastasis has occurred is of very limited value using radiation, chemotherapy, or immunotherapy. However, surveillance and the early detection approaches have not been widely used. If the proper criteria can be met it is still a vast untapped direction of medical effort. People who are living today, and who will develop cancer before a therapeutic cure can be effected, can be cured by finding the cancer while they are asymptomatic or by removing the premalignant lesion.

The Heme-Occult Program in Northwest Ohio is now two and one half years old and serves approximately 17 counties in Northwestern Ohio. It is a program that is in continuous progress and can serve as a working model for similar local activity. Results thus far for the detection of malignant and nonmalignant disease have been extremely impressive. It appears that we are detecting two to three times the present rate of diagnosis of two cancers per thousand of people over 50 years of age.

Of the 18,000 persons who have participated, 72 cancers of the large intestine have been diagnosed. Of these 72, 35% of the cancers are still confined to the adenomatous polyp of their origin instead of the 5% to 10% that are previously reported in surgically removed colorectal cancers. The total numbers which are classified as Duke's A* or Duke's B** lesions make us believe that we can achieve the predicted 80% cure rate for this most common cancer afflicting American people. A definitive survey of the program now is being compiled for publication.

This program is economically feasible despite the cost of the follow-up for patients who are found at risk. These are people who have seen visible blood in their stools or have guaiac positive stools on chemical testing. The cost of detection of colorectal cancer parallels the Pap test and perhaps with further refinements of diagnostic follow-up, could be made many times less expensive.

The Heme-Occult Program has an excellent organizational setup that could be used in rural and urban areas. The criteria for success of the program depends on the following: (1) it is essential to have physician and public approval; (2) the program should be inexpensive with a good degree of accuracy; (3) the procedural plan should be simple; (4) there should be good compliance by the public; and (5) compilation of statistics is essential to determine the favorable or unfavorable direction any program is going.

There are several problems we have found that are resolvable but are still extant in the program. From the point of view of the asymptomatic person over 40 years of age, he has a hope that *it* cannot happen to him. This is not a reasonable attitude. Elderly patients often philosophize by saying, "If I could only live a few more years I do not care what happens then." We do not find this to be true after he develops cancer. At that time he wishes to live longer and to be cured.

There is a constant almost paralyzing fear of cancer among the majority of the population with colorectal symptoms regardless of whether the signs and symptoms are due to malignant or nonmalignant disease. They consistently seek self-care during the period of time that they could be cured through medical surveillance followed by appropriate diagnosis and treatment.

The Hemoccult slide does not lend itself well as an office procedure in direct patient-to-physician relationship because it interests only a limited number of physicians, primarily family practitioners, internists, and surgeons. Persistent enthusiasm even by this group is difficult to maintain, and other medical specialties do not involve themselves in colorectal cancer. A physician may have thousands of charts in his office but is probably seeing a small fraction of these patients in any one month. The patient-physician relationship does not maintain a social pressure to induce people to participate and to comply with the procedure. This is perhaps the most important facet of any medical surveillance program, and with a continuation of the program it should be solved.

There are several problems inherent in the diagnostic work-up. In the studies we utilize all the physicians in the community for diagnosing patients who are at risk. Frequently there is an incomplete work-up and, as a result, many adenomatous polyps that should be removed are being missed. In my opinion, the rigid sigmoidoscope is suspect because it has never developed good patient or physician acceptance. The scope tends to cause a great deal of pain and patients fear it. The use of the sigmoidoscope by the physician is limited because frequently the scope is not inserted to its full 25 cm due to the pain and discomfort to the patient.

There is a question of who should do endoscopy. The flexible sigmoidoscope is an excellent new instrument and the use of it is easily learned with a short period of instruction by competent instructors and could easily be a device adopted by the family practitioner. He should adhere to two criteria in performing endoscopy. The first is that the patient should be asymptomatic with a positive Hemoccult. The other is that the patient should not have had previous pelvic or abdominal surgery.

Medical surveillance programs are not new but they have been largely ineffectively used in bringing people into the health care delivery system. We feel that we are demonstrating through the Heme-Occult Program that early diagnosis can be achieved before an already ill patient becomes symptomatic and probably incurable of colorectal cancer. This point of view also can be applied to many of the major diseases that afflict mankind. The cost of a program such as this is miniscule compared to many of our other medical activities. The Heme-Occult Program of Northwest Ohio can be a model for similar programs throughout Ohio.

* Duke's A - Colorectal carcinoma confined to bowel wall with no lymph node metastasis.

** Duke's B - Colorectal carcinoma extending beyond the bowel wall with no lymph node metastasis.

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Features

Forging New Alliances 193

Richard S. Schweiker, the new Secretary for Health and Human Services, recently addressed members of the American Medical Association, promising a new kind of alliance between government and the medical profession. Excerpts from his speech are included here.



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The OSMA Annual Meeting Special Section ... 197

All the details for this year's Annual Meeting, to be held May 16-20 in Cleveland, Ohio, are to be found in this special section of the *Journal*.



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A Real Cliff Hanger 239
Gina C. Cummins

When this Beverly, Ohio physician wants a good time, he goes straight to the top.



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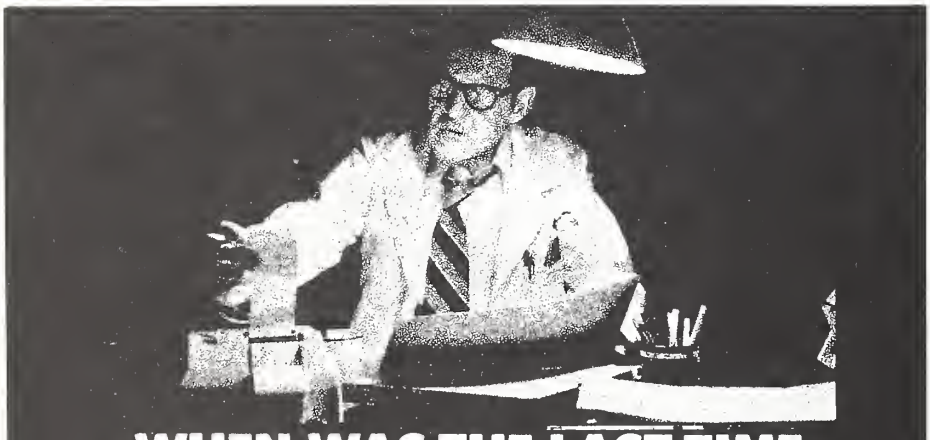
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Letters ...to the editor

COMMUNICABLE DISEASE REPORTING

To the Editor:

We have read with interest your article on Ohio's Communicable Diseases which appeared in the *Ohio State Medical Journal*, December 1980. We would like to congratulate you and the staffs of the Ohio State Medical Association and the Ohio Department of Health on the actions you have taken to improve the coordination of the reporting of communicable diseases in Ohio.

Sincerely yours,
/s/**Ned E. Baker**
Associate Executive Director
Health Planning Association of
Northwest Ohio

To the Editor:

This letter is in reference to your article in the December 1980 issue of the *Journal* regarding physician reporting. We at the Ohio Department of Health are concerned because the format of the article placed too little emphasis on the problems physicians face in the system and failed to mention a number of specific recommendations.

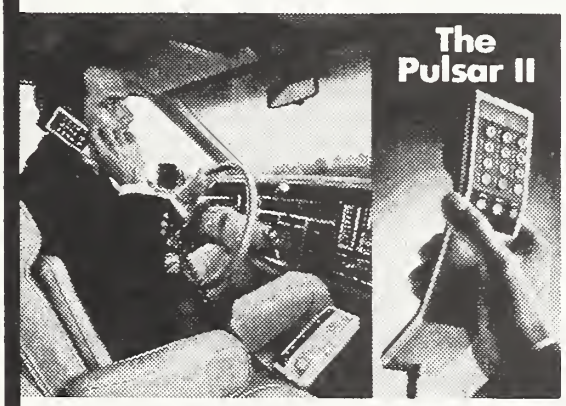
We would like to utilize this format to specifically list some of the recommendations that were omitted from the article.

1. It is important that a representative of each local health department attend county medical society meetings as often as possible but at least on an annual or semi-annual basis.
2. The Ohio Department of Health (ODH) should encourage physicians to use the toll free number to rapidly report problems (1-800-282-0546).
3. The ODH should work with Ohio's medical schools.
4. Multiple health jurisdictions are confusing and frustrating to physicians and are a hindrance in reporting. ODH should investigate the potential of one central reporting office in each county.

We feel that this letter will give a more complete perspective to the problem of communicable disease reporting in Ohio.

Sincerely,
/s/**Thomas J. Halpin, M.D., M.P.H.**
Chief, Bureau of Preventive Medicine
/s/**Frank Holtzhauer**
Supervisor, Epidemiology Unit, ODH
/s/**Seth Young**
Research Analyst, ODH

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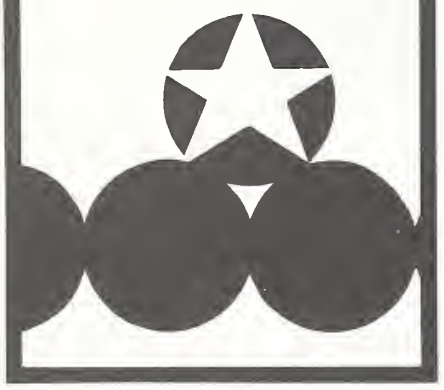
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COLLEAGUES IN THE NEWS



MILED ALBAINY, M.D., Cleveland, was elected president of the Parma Community General Hospital medical staff. Dr. Albainy is a member of the pathology division.

Other officers elected include: **CHARLES LI, M.D.,** vice-president; **JAMES F. RAMBASEK, M.D.,** secretary; and **NICHOLAS DEYCHAK, M.D.,** treasurer.

HOMER A. ANDERSON, M.D., Columbus, was reelected president of the board of trustees of the Medical Bureau. **JAMES E. MATSON, M.D.,** was elected secretary-treasurer.

ESLIE ASBURY, M.D., was chosen by the Cincinnati Chamber of Commerce to receive the "Great Living Cincinnatian" award. Dr. Asbury specializes in general and orthopedic surgery.

PERRY AYRES, M.D., Columbus, was elected president of the Harding Hospital medical staff. **THOMAS KING, M.D.,** was elected vice-president, and **S.R. THORWARD, M.D.,** was reelected secretary-treasurer.

FELINO V. BARNES, M.D., North Royalton, was elected president of the North Royalton Board of Education. Dr. Barnes was school board president twice before and is completing his second four-year term of office as board member.

DONALD BRINKMAN, M.D., Cincinnati, was reelected as chief of the medical staff of Our Lady of Mercy Hospital. Dr. Brinkman specializes in urology.

Other officers reelected include **WALTER RUGH, M.D.,** vice-president, and **JOSEPH STAGAMAN, M.D.,** secretary-treasurer.

WILLIAM G. CASSEL, M.D., Oakwood, was elected chief of staff of Kettering Medical Center. Dr. Cassel has been a member of the medical staff since 1973, and is in the practice of internal medicine and cardiovascular disease.

THEODORE J. CASTELE, M.D., Cleveland, has won the Gold Award in Category I of the 1980 AMA National Awards Program for Medical Speakers.

SYLVESTER S. DAVIS, M.D., Cleveland, was elected president of the Cleveland chapter of the National Association for the Advancement of Colored People (NAACP). He has been active in the NAACP since his teens. Dr. Davis is director of the division of gynecology and reproductive health at St. Luke's Hospital, has a private practice, and teaches medicine at Case Western Reserve University.

THOMAS E. DICKE, M.D., Lima, was elected chief of staff of St. Rita's Medical Center. Dr. Dicke is a pathologist in St. Rita's laboratory. Other officers elected include **WILLIAM P. LAUF, M.D.,** chief of staff elect, and **ROGER L. TERRY, M.D.,** secretary-treasurer.

JAMES G. DILLER, M.D., Toledo, received the Sertoma Club of Toledo's annual Service to Mankind Award for his humanitarian surgical services as a medical missionary in Haiti. Dr. Diller is involved in hospital staff and committee work at Flower, Toledo, and St. Luke's Hospitals and serves as clinical assistant professor in plastic surgery at the Medical College of Ohio.

AMASA B. FORD, M.D., Cleveland, was appointed first associate dean for geriatric medicine at Case Western Reserve University School of Medicine. Dr. Ford is a member of the Geriatric Medicine/Gerontology Advisory Committee of the Ohio Board of Regents; president of the board of trustees of the Eliza Bryant Center Nursing Home; senior associate to the Case Western Reserve University Center on Aging and Health; and a member of the executive committee of the Western Reserve Center for Long Term Care of the Elderly.

FRANK E. FOSS, M.D., Toledo, was reappointed to the Ohio Board of Regents Paramedic Advisory Committee. Dr. Foss currently serves as president of the Academy of Medicine of Toledo and Lucas County.

THOMAS R. FRYE, M.D., Columbus, was elected president of the Children's Hospital medical staff. Dr. Frye, a chief radiologist, is chairman of the medical executive committee and clinical professor of radiology at Ohio State University College of Medicine.

VALERIE J. GILCHRIST, M.D., Poland, was appointed associate director of the Family Practice Center for Youngstown Hospital Association. Dr. Gilchrist is an assistant professor for the Department of Family Medicine at Northeastern Ohio Universities College of Medicine.

GILBERT WAYNE HOPKINS, M.D., Dayton, was elected chief of staff of St. Elizabeth's Medical Center. Dr. Hopkins has been on the staff of St. Elizabeth's since 1961.

CONRADO JAVIER, M.D., Cleveland, was elected president-elect of the St. Alexis Hospital medical staff. Dr. Javier is chairman of the Cardiopulmonary Resuscitation Program and currently is president of the St. Alexis Professional Group, Inc.

WILLIAM E. FORSYTHE III, M.D., Cleveland, was elected secretary. Dr. Forsythe is a urologist.



Theodore J. Castele, M.D., . . . winning the gold.

HENRY LEUCHTER, M.D., Columbus, was named president-elect of the Mental Health Association of Franklin County.

A national award was presented by the Community MedCenter Hospital and Frederick C. Smith Clinic to **ALBERT N. MAY, M.D.,** "whose extraordinary awareness of the potential of the International Year of the Child motivated statewide community action on behalf of the health needs of Ohio children." Dr. May is a pediatrician and chairman of the Central Ohio Committee for the IYC.

Clermont County Hospital's new lecture hall has been named for **CARL A. MINNING, M.D.,** a general practitioner in Batavia. Dr. Minning has practiced medicine in Clermont County since 1932.

CONSTANTINE PEREYMA, M.D., Piqua, was elected chief of staff of Stouder Memorial Hospital. Dr. Pereyma specializes in surgery.

JAMES J. POSCH, M.D., Mayfield Village, was elected president of the Hillcrest Hospital medical staff and chairman of the medical council. Dr. Posch is chief of the pediatrics department at Hillcrest and a clinical pediatrics professor at Case Western Reserve University's School of Medicine.

ROLAND A. REICH, M.D., Piqua, recently retired from his practice of medicine at Stouder Memorial Hospital, was made an honorary staff member upon a recommendation from the board of trustees and medical staff of the hospital.

M. M. RESSALLAT, M.D., Galion, was elected chairman of the board of trustees of the North Central Technical College in Mansfield. Dr. Ressallat maintains a medical practice in Galion and is former chief of staff of the Galion Community Hospital.

THOMAS E. SHAFFER, M.D., Columbus, was named chairman of the American Academy of Pediatrics Committee on Pediatric Aspects of Physical Fitness, Recreation and Sports. Dr. Shaffer is a specialist in adolescent medicine and clinical director of the Teenage Clinic at Children's Hospital.

MARGARET SHIPLEY, M.D., North Canton, was appointed to the Health Planning and Development Council's Plan Development Committee. Dr. Shipley is a retired pediatrician and is involved with the Stark County Welfare Advisory Committee as well as Parents Anonymous of Stark County.

O. DAVID SOLOMON, M.D., Cleveland, was appointed head of the Contact Lens Clinic in the Division of Ophthalmology, Mt. Sinai Hospital. **DAVID B. SHOLITON, M.D.,** was appointed head of Residents' Training and Education.

JOHN E. VERHOFF, M.D., Columbus, was appointed to the Parke/Davis Teacher Development Awards Committee, and **RONALD C. VAN BUREN, M.D.,** Columbus, was appointed to the Commission on Membership and Member Services of the American Academy of Family Physicians.

JEROME A. WENSINGER, M.D., was appointed 1981 Cancer Crusade chairman in Marion County. Dr. Wensinger has been practicing in Marion for 16 years and is active in numerous medical societies.

THOMAS E. WILSON, M.D., Warren, was reelected president of St. Joseph Riverside Hospital medical staff. Dr. Wilson is an internal medicine specialist and has served at St. Joseph since 1950.

MICHAEL J. CASALE, M.D., Warren, was elected vice-president. Dr. Casale specializes in obstetrics and gynecology. **C.H. CHUNG, M.D.,** Howland, a urologist, was elected secretary-treasurer.

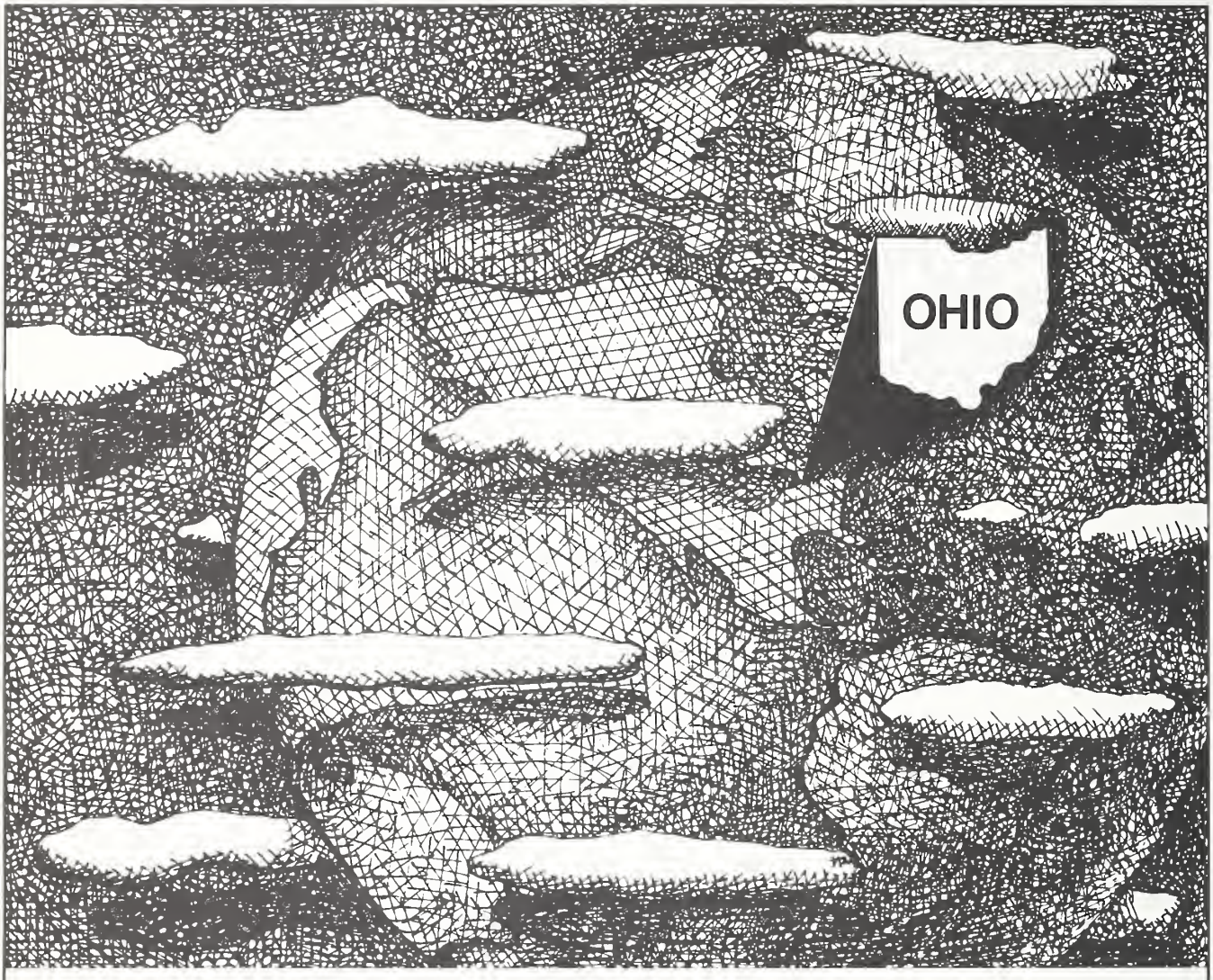
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STATE

HOSPITAL LICENSURE REINTRODUCED

House Bill 173 (J. Thompson, D-Cleveland) establishes an Ohio hospital licensure law incorporating the standards of the Joint Commission on the Accreditation of Hospitals (JCAH). JCAH accreditation of a hospital would establish a presumption of compliance with licensure standards. The bill limits hospital admitting privileges to physicians and dentists, with coadmitting privileges for podiatrists.

HB 173 is a redraft of HB 753, the hospital licensure bill introduced by Rep. Thompson last session.

Although HB 753 passed the House last year and was assigned to the Senate Finance Committee, no further vote was taken. HB 173 is being heard in the House Health and Retirement Committee.

BRAIN DEATH

State Senator Paul Matia (R-Westlake) has introduced SB 98, providing statutory criteria for the determination of death. The bill meets the guidelines established by OSMA Resolution 11-80. An individual would be declared dead if he or she "has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards."

SB 98 provides legal protection from criminal and civil liability to any physician, and any person whose actions are based on a physician's determination of death. The bill has been referred to the Senate Judiciary Committee.

LIVING WILLS

Two bills providing statutory recognition of "living wills" in Ohio have been introduced. HB 137 (Nettle, D-Barberton) and SB 59 (Cox, D-Barberton) are redrafts of SB 400, introduced by Senator Cox last session. Both bills protect physicians as well as other health care personnel and facilities, from civil or criminal liability when he or she withholds or withdraws life-prolonging measures in accordance with a directive of a terminally ill patient.

The bill was drafted by the Columbus-based Association for Freedom to Die. Last session SB 400 received several hearings in the Senate Judiciary Committee. HB 137 is being heard in the House Civil and Commercial Law Committee. SB 59 has been referred to the Senate Health and Human Resources Committee.

THREE ABORTION BILLS THIS SESSION

Representative Ken Rocco (D-Parma) has teamed with freshman Representative Ron Suster (D-Euclid) in sponsoring a package of abortion legislation. HB 92, HB 93, and HB 94 contain essentially the same provisions as proposed by Representative Rocco's HB 879 last session. HB 879 received several hearings in a subcommittee of the House Judiciary Committee last year; however, no vote on the measure was ever taken. The three bills introduced this year have been referred to three different House committees.

HB 92 would require any physician performing an abortion to present certain specific information to the pregnant woman concerning development of the fetus, the physical and emotional risks of abortion, and the alternatives to abortion. The bill prohibits a pregnant unmarried minor from obtaining an abortion unless she has received parental consent or consent from a juvenile court. HB 92 is in a subcommittee of the House State Government Committee.

HB 93 would prohibit an abortion, if the fetus is viable, unless the abortion is necessary to preserve the life or health of the pregnant woman. A second physician's presence would be required during all abortions, and the abortion method least likely to harm the viable fetus would be required, unless the method would be harmful to the pregnant woman's health. HB 93 is before the House Judiciary Committee.

HB 94 would expand the record-keeping requirements for abortion procedures, and would establish a procedure for registration and inspection of abortion facilities by the Ohio Department of Health. The definition of "abortion facility" includes the offices of physicians. The bill is before the House Health and Retirement Committee.

MEDICAL BOARD LEGISLATION INTRODUCED

Legislation providing for the biennial registration of physicians and expanding the authority of the Ohio State Medical Board has been introduced by Representative John Thompson (D-Cleveland). Similar to SB 368 (Roberto, D-Ravenna) introduced last session, HB 310 will increase the Board's funding to hire more investigators and attorneys, and will provide the Board subpoena powers. The bill has not yet been assigned to committee.

Similar legislation has been introduced by Representative Ken Rocco (D-Parma). HB 210 would also expand the powers of the State Medical Board and require the biennial registration of physicians. The bill expedites the appeals process for Board orders and increases physician licensure fees. HB 210 has been assigned to the House Health and Retirement Committee.

FEDERAL

REAGAN BUDGET OUTLINED

The Reagan Administration has proposed a FY 1982 budget of $695.5 billion with major federal health funding targeted for deep cuts. Medicare, however, is one of several "safety net" programs spared to prevent excessive suffering by the poor.

There would also be cuts in the FY 1981 budget, although the major impact of budget reductions would not

be felt until next year. While there would be increases in dollar expenditures outlays would increase to a level well below the current inflation rate. If the President's cuts were to go through Congress in their present form, the federal budget's growth would be slowed from the current sixteen percent annually to seven percent. If the Reagan tax and budget cut projections mesh with supply-side expectations, the federal budget will be in balance in fiscal 1984. Health and health-related programs targeted for cuts or elimination include food stamps, Social Security disability, Medicaid, child nutrition, the National Institutes of Health, health training, health maintenance organizations (HMOs), the National Health Service Corps, health planning, Professional Services Review Organizations (PSROs) and forty health and social service categories.

Federal Medicaid payment increases would be limited to five precent annually, starting in FY 1982, as compared to a federal increase of eighteen percent in the current fiscal year.

Health training subsidies would be cut by $32 million this year and would be reduced by $313 million to $120 million in FY 1986. The Administration has taken the position that "capitation" grants for medical and dental schools are no longer necessary because of projected surpluses of physicians and dentists.

HMO grants and loans would be cut $6 million this year and phased out completely by FY 1986. The Reagan Administration is of the opinion that HMOs must stand on their own without federal support, and that existing regulations impose overly stringent benefit requirements and standards.

The new Administration has also taken the position that health planning has raised costs by shackling competition. It would cut health planning outlays by $10 million and would phase out the program by FY 1985.

The Reagan Administration also feels PSROs are not cost effective; and that they in fact cost more than they save. It would cut funding by $38 million this year and eliminate the program by FY 1984.

FDA PUTS PATIENT PACKAGE INSERT PROGRAM ON HOLD

The Federal Food and Drug Agency has halted the Patient Package Insert (PPI) program just as manufacturers began preparation and printing of PPIs for May distribution. The indefinite delay which has the strong support of the American Medical Association, came on the heels of President Reagan's executive order to reconsider regulations that might cost $100 million or more, increase costs of products, or adversely affect competition. Questions have been raised concerning the program's impact on patient treatment and cost. The delay will give the FDA and the Office of Management and Budget time to re-examine th cost-effectiveness of the PPI concept.

"NATIONAL HEALTH CARE REFORM ACT OF 1981" INTRODUCED BY CONGRESSMAN GEPHARDT

HR 850 introduced in the Congress January 16, 1981, by Rep. Gephardt (D-Mo.) would substantially alter the present delivery of health services in the United States. Like other pro-competition bills, it would use the tax laws to encourage the availability of multiple health insurance plans to health care consumers. Unlike other proposals, however, the Gephardt bill would not require employers to actually offer health insurance programs to employees.

Every year, citizens and lawful resident aliens of the United States would become eligible for federal **"healthcare contribution"** annually set by the Secretary of Health and Human Services. For employees this contribution would take the form of an exclusion from gross income in an amount equal to an employer contribution toward the payment of a premium in a "qualified" plan selected by the **employee.** Every year the employer would determine the amount of contribution that would be made on behalf of each employee. In the event an employee chose a plan costing less than the amount of the employer's contribution, the employee would be entitled to receive the difference in the form of cash or other benefits, and would be considered tax-free income to the employee to a maximum of $500 per year.

If the individual was not an employee but was self-employed, the federal "healthcare" contribution would take the form of a refundable tax credit equal in tax benefits to that provided eligible employees. Beneficiaries under Medicare would be given an option to enroll in a local "qualified" plan which would offer improved benefits over the current program. A voucher system would also enable low income individuals to buy plans, thus extending "competition" to those now receiving benefits under Medicaid.

OMB RESCINDS HOSPITAL CONSTRUCTION MEMO

On February 20, the federal Office of Management and Budget (OMB) rescinded its Memorandum of December 19, 1980 which would have established policies and procedures to limit federal financial support for hospital construction in "overbedded areas." No federal financial support would have been provided for hospital development in such areas unless an area had developed an HHS-approved hospital facilities plan providing for a reduction of "excess bed capacity." The AMA was critical of the fact that OMB would take the definitions of the terms "overbedded area" and "excess bed capacity" directly from the voluntary National Guidelines for Health Planning. Many organizations, including the AMA, submitted statements of objection to the OMB following the initial proposal of the Memorandum last June.

NEW LEGISLATIVE DIRECTORIES TO BE MAILED SOON

The OSMA Ohio Legislative Directories for the 114th General Assembly are finally ready for distribution! Printing was delayed several weeks due to last-minute changes in committee assignments. All OSMA members will receive a copy of the Directory with the next OSMAgram. Extra copies are available on request.

The directory lists names, phone numbers, addresses and committee assignments of Ohio's Congressmen, U.S. Senators, State Representatives and State Senators.



SECOND OPINION

The Counter-productivity of CME

By C. L. Barrett, M.D.

I will probably spend less time in the future attending medical meetings.

One reason is that they simply cost too much. Meetings which used to cost $50 to $200 now cost two to four times as much, and while inflation may be part of the reason for the soaring costs, the compulsory nature of medical education is as much to blame.

Medical education has, in fact, become a one to three billion dollar industry (according to which authority you read) — but the demand for physicians' money does not stop. While we're shelling out $5-$20 an hour for a course to meet requirements, we're being handed a bill for hotel accommodations which follow the same spiraling patterns. Frankly, I feel that $96 a day at the Sheraton Towers in Orlando, Florida is too much.

The problem is that the quality of these courses has not improved with the costs. Each group which sponsors a medical education course begins with enough enthusiasm, but that enthusiasm dwindles over the years, and after ten years in the "business," the courses become dull and repetitive. Too many of them would qualify as sophomore medical school lectures, and too many recapitulate facts that have been offered 5, 15, and 25 times before.

I probably received more information — and inspiration — from my days spent at the hyperbaric clinic in Ft. Lauderdale. There were no CME credits then, but the facts and techniques which I learned then are still with me. I can't forget them. Conversely, I can't remember a single beneficial fact I learned from hours spent in CME courses.

An educational program should give you something — a new tool which will help in the treatment of patients, or perhaps a new technique. Now the only thing which is being given is credit.

I remember attending a one-day, out-of-state medical lecture in acupuncture, which was being sponsored by a commercial firm. While I was there, I met three physicians who had recently attended a course on the same subject, several days in length, and sponsored by a prominent medical school. They were disgruntled because they felt they had discovered more new — and accurate — information from the one-day commercial meeting than in the length of time they had spent at the medical school meeting. The only benefit they received from that course, it seems, is the credit hours they accumulated. It's frightening to think that a medical school would cash in on the flood of interest in acupuncture without having the qualified personnel to adequately handle the subject. But more worrisome is the question which this example raises — is this really medical education?

My son feels that CME courses are currently cluttered by attendees who are not interested in, nor appreciative of the material being presented. They are there for one reason — to earn the necessary credit hours for their CME requirements.

Why do I decry the type of education we currently receive under the guise of CME? Why do I remember an early technique for performing a Caesarian section, but can't recall a single good fact learned in the last six months? Have I missed something new in the recapitulation of facts, or has the very reason for continuing medical education become lost in the mire of required credit hours?

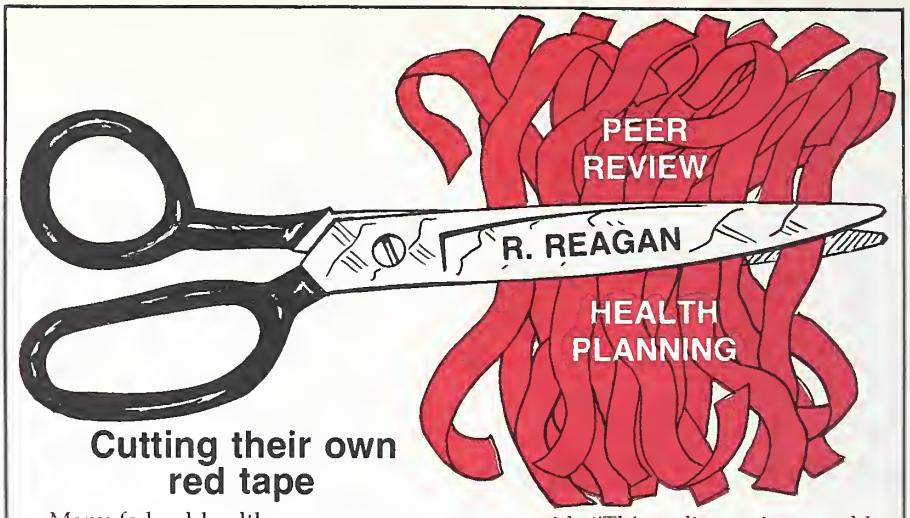
"Have I missed something new in the recapitulation of facts, or has the very reason for continuing medical education become lost in the mire of required credit hours?"

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by Karen S. Edwards



Cutting their own red tape

Many federal health programs are marked for heavy cuts by the Reagan Administration. A package of proposed cuts, prepared by the Administration budget team headed by Office of Management and Budget director David Stockman, is being circulated among key congressmen.

One target of these cuts is health planning, which would be phased out over the next two years. The budget team said, "This policy action would be consistent with a two-year Administration timetable for development and implementation of a pro-competitive bill for health financing reforms." Planning was criticized in the document for lack of effectiveness, inappropriate regulation, and for federal intrusion on state and local responsibilities.

Laetrile studies continue

An initial study of the controversial drug laetrile (or amygdalin) conducted under the direction of the Mayo Clinic in Rochester, Minnesota, determined that the drug is safe to consume, but so far no conclusions have been made on the drug's effectiveness.

Charles R. Moertel, M.D., head of the study at the Clinic, points out in a report recently published by the *Journal of the American Medical Association*, that the sample of six patients was too small to provide results on the effect of the drug.

"The administration of amygdalin according to the dosages and schedules we employed (based on the popular treatment dosages) seems to be free of significant side effects," Dr. Moertel says.

The report is the first phase of the National Cancer Institute's test of laetrile on humans. The next phase will test the drug's potential anticancer activity.

Foundation announces new funding objectives

David E. Rogers, M.D., President of the Robert Wood Johnson Foundation, the country's largest private grantmaker in health, has announced a new set of funding objectives in this year's annual report.

"Under our first new objective, we want to help doctors and others develop health care approaches which will maintain quality but will result in cost savings for patients," Dr. Rogers said. Priority will be given to projects which can make material improvements but will reduce the rate of health care costs nationally, he added.

The report states that the Foundation will also continue to assist groups and institutions attempting to improve access to personal health care for the country's most underserved population groups.

Radiation therapy for breast cancer

A group of radiation therapists are recommending that women with early breast cancer consider undergoing radiation therapy in conjunction with simple surgery to remove only the cancerous lump rather than the entire breast.

The control rates of radiation therapy combined with surgery are comparable with those obtained by modified or radical mastectomy, says Luther W. Brady, M.D., Chairman of the Department of Radiation Therapy and Nuclear Medicine, Hahnemann Medical College, Philadelphia.

The procedure, reviewed in a recent issue of the *Journal of the American Medical Association*, has become even more important, he adds, with the increase in detection of breast cancer at an early stage.

Meetings

June

"Surviving and Thriving," the Annual Meeting of the Ohio Public Health Association: June 8-9, Hyatt Regency Hotel, Columbus, Ohio. National, state, and local people who are involved with health will describe programs which are functioning effectively in spite of budget and personnel cutbacks. For more information please contact: Mary Gries, OPHA Secretary, P. O. Box 14331, Columbus, Ohio 43214.

11th Annual Emergency Medical Care Seminar: June 9-11, Executive West Hotel, Louisville, Kentucky. The seminar will feature manual skills workshop and technical exhibits in addition to discussions of Multiple Systems Injuries, Child Abuse, and Acute Psychiatric Disorders. For more information, please contact: The Kentucky Medical Association, 3532 Ephraim McDowell Dr., Louisville, Kentucky 40205.

July

Annual Symposium on Contemporary Neurology: July 21-25, Palmetto Dunes Hyatt Resort, Hilton Head Island, South Carolina. Sponsored by Vanderbilt University School of Medicine, Nashville, Tennessee. For more information, please contact: Mrs. Joan Sullivan, Department of Neurology, Vanderbilt University School of Medicine, Nashville, Tn. 37232.

Ear, Nose & Throat Symposium for the Family Physician: July 31-August 2, The Lodge in Vail, Vail, Colorado. Sponsored by the Associates of Otolaryngology in affiliation with the combined medical staff of Porter Memorial Hospital, and the Swedish Medical Center. For further information, please contact: Lisa Lee, 950 E. Harvard, Suite 500, Denver, Colorado 80210.

Ohio State Medical Golfers set tournament date



Donald N. Beddard, M.D., Mansfield, demonstrates the putting style that helped him capture low net honors in the 1980 Ohio State Medical Golfers Association Tournament.

The Ohio State Medical Golfers Association (OSMGA) will hold its 1981 tournament on Friday, June 12, at Ashland Country Club, Ashland, Ohio. Preregistration forms and other information will be mailed to OSMGA members in mid-April.

Physicians wishing to join OSMGA should write to the Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215. There is no membership fee. The registration fee includes greens fee, luncheon, banquet, locker room tips, and prizes.

Tournament capacity will be 150 players — on a first-come, first-served, preregistration basis.

OSMGA President is C.J. Shamess, M.D., of Mansfield. Serving on the OSMGA Board of Trustees are David M. Bell, M.D., Cleveland; Donald W. English, M.D., Lima; James S. Greetham, M.D., Marion; John A. Kramer, M.D., Ada; Edward A. Sawan, M.D., Akron; John C. Stahler, M.D., Dayton; and Edward Zartman, M.D., Columbus.

MISCELLANEA

• In the area of health education, the people at Johnson & Johnson have initiated an employee health program entitled "Live for Life" which is attempting to improve the lifestyles of their employees. Created with the aid of medical doctors and experts in the areas of behavioral science and physical fitness, the "Live for Life" program is unique in that it focuses on the worksite as a source of self-help information.

• The National Institute on Aging has copies of their brochure *Biochemistry of Aging*, available for general distribution. The brochure includes discussions on such topics as: the changes in the metabolism of lipids and glucose; cultured fibroblasts as a cellular model of senescence; and the physiological consequences of age-dependent modifications in collagen metabolism. Free single copies of the brochure are available by writing: NIA/Biochem, Expand Associates, 8630 Fenton St., Suite 508, Silver Spring, Md. 20910.



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—from *The Art of Poetry* (1674) by Nicholas Boileau-Desprēaux

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Louis Saslaw



Gina C. Cummins

Two new staffers join OSMA PICO announces new appointments

Two new staff members have recently joined the Ohio State Medical Association (OSMA), and the Physicians Insurance Company of Ohio (PICO) has just announced two major management appointments.

Joining the OSMA's Department of Field Service as Assistant Director is Louis N. Saslaw, a psychology graduate of the University of Michigan, who holds his master's degree in Public Administration from Ohio State University. Saslaw has served as both Director of Youth Programs and Fund-Raising Coordinator for the Central Ohio Diabetes Association, and was the Ohio field representative for the American Diabetes Association (ADA) before joining the OSMA. As field representative, Saslaw was instrumental in developing voluntary chapters of ADA in counties throughout Ohio. Presently, he serves with Field Service Director, Robert Holcomb, as liaison between OSMA and Ohio's county medical societies..

Gina C. Cummins joins the OSMA's Department of Communications as staff writer and as Assistant Editor of *Synergy,* OSMA's health education publication. A journalism graduate of Youngstown State University, Cummins' professional background includes experience as an advertising copywriter for Lazarus Department Stores in Columbus. Under the direction of *Synergy* Editor, Carol Mullinax, and Department Director, Rebecca J. Doll, she will be responsible for writing for both *Synergy,* and for the *Ohio State Medical Journal* (her first article appears on page 239 of this issue).

At PICO, David P. Kaechele, formerly the company's senior vice-president and treasurer, has been named to the newly-created position of Executive Vice-President. David L. Rader, PICO's Senior Vice-President and Secretary has recently been elected President of PICO Life Insurance Company. Rader was formerly Director of State Legislation for the OSMA.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the **male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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REFER TO PDR

Forging New Alliances

Editor's Note: The following article is excerpted from a speech which Richard S. Schweiker, the new Secretary of Health and Human Services (HHS), gave before the American Medical Association at its National Leadership Conference this past winter. His remarks offer important insight into the relationship currently being developed between the medical profession and the new Reagan Administration.

I will initially target my energies in several critical areas. First, the social security system must be protected and maintained in a manner that ensures its long-term financial integrity. Current social security recipients must be assured they will continue to receive benefits and that benefit levels will not erode over time. Just as important, those who contribute their hard-earned dollars to the social security system must have confidence their security is guaranteed when retirement comes. To restore this confidence will be my top priority as secretary. The recommendations we develop will be positive, practical, and constructive. The acid test will be their acceptability to the new Congress.

As you know, there are numerous problems with the present welfare system that this administration plans to address quickly. We need to reduce the federal regulatory requirements imposed on the states, and reverse the trend toward welfare dependency in this country.

Our goal is to return control of welfare programs to the states. The states are closer to the people they serve and are in a better position to be responsive to needs of the poor and disadvantaged.

Another priority on my agenda will be to wage an all-out war on fraud, abuse, and inefficiency in the activities supported by the Department. I plan to revitalize the office of inspector general, which has yet to be utilized to its full potential. This office will be dogged in its pursuit of fraudulent conduct and unflinching in its investigation of abusive practices. From counterfeiting of social security cards to kickback schemes by health care providers, no institution, individual, or activity supported by the Department will be immune from scrutiny. Studies have also shown us that substantial potential savings could be achieved by eliminating waste and inefficiency in program administration.

I intend to focus considerable attention on reducing and erasing unnecessary regulation. I am sure each physician has his own favorite example of a federal requirement which affords little if any benefit to the patient, yet costs valuable time and effort to comply with. I want to find those unnecessary rules and wipe them from the books.

The Department of Health and Human Services will lead the way toward regulatory reform. In doing so, we will satisfy our responsibility to help those truly eligible and in need — and in a cost effective manner. The result will be better programs that can meet the original goals set out for them. As providers familiar with the vagaries of government rules, I look to you for suggestions for realistic changes.

It is time we assessed the value of our federal investments. For those medical institutions whose cornerstones were laid on a financial base buttressed with federal funds, it is time to test their fiscal strength and their ability to generate private support.

We can expect to see the states given a greater share of available funds and greater latitude for determining how it is spent. For our part, we must be willing to provide the flexibility they require to bring about true systems reform. Further, we must be willing to offer appropriate incentives.

As one who believed from the beginning in the laudable objectives of the health industry's voluntary effort, I pledge to you my continued support and any available resources in assisting to make the voluntary effort a true success. I remain convinced the best way to achieve the goal of quality health care at an affordable cost is through the efforts of enlightened and conscientious providers. We must now, more than ever, prove we can achieve that goal voluntarily.

A goal I have set for myself as Secretary of Health and Human Services is to put preventive medicine and preventive health care at the very top of the Department's health agenda. For example, I would consider using tax policy to encourage employers to offer preventive services; to sponsor health education activities; and to foster health promotion to their employees. We could also restructure reimbursement policy to favor those preventive services with a potential for cost effectiveness. With your help, I hope to move prevention from medicine's stepchild to its favorite son. As leaders in the health field, I enlist your involvement in this crusade. Only with your dedication can we hope to see real progress toward a medical system where prevention is accepted practice. Such an undertaking could yield handsome dividends for future cost containment as well.

I will strive to make increased competition a theme in my approach to change health programs. Government policies, whether direct or indirect, should be shaped to provide appropriate incentives to foster competition and consumer choice.

We must have the courage to depart from conventional theories and test new ideas and concepts. Armed with new alternatives, we need implement only those which have survived the test of rigorous field trial. I solicit your help and expertise in this endeavor. Your ideas, but most of all your cooperation, will be necessary ingredients if we are to have successful ventures.

Editor's Note: In his address, Secretary Schweiker says, "I am sure each physician has his own favorite example of a federal requirement which affords little if any benefit to the patient, yet costs valuable time and effort to comply with. I want to find those unnecessary rules and wipe them from the books." Do you have a "favorite example" of such a federal requirement? If so, send it to us in care of the OSMA Journal. We'll compile the examples we receive and forward them to Secretary Schweiker.

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Candidate for President-Elect

C. DOUGLASS FORD, M.D.

OSMA Annual Meeting
May 16-20, 1981
Stouffer's on the Square
Bond Court
Cleveland, Ohio

C. DOUGLASS FORD, M.D., Toledo internist, has been nominated for the office of President-Elect of the Ohio State Medical Association. His name was placed in nomination by the Academy of Medicine of Toledo and Lucas County. Academy President, Frank E. Foss, M.D., wrote the following letter:

Mr. Hart F. Page
Executive Director
Ohio State Medical Association
600 S. High Street
Columbus, Ohio 43215

Dear Mr. Page:

By Constitutional privilege, The Academy of Medicine of Toledo and Lucas County is pleased to nominate C. Douglass Ford, M.D., Fourth District Councilor, as a candidate for the office of President-Elect of the Ohio State Medical Association.

Dr. Ford is qualified, by membership in good standing in The Academy of Medicine of Toledo and Lucas County, the Ohio State Medical Association and the American Medical Association. He has repeatedly demonstrated his dedication and leadership in organized medicine by his many years of involvement with The Academy of Medicine, six (6) years as Councilor from the Fourth District to the OSMA and as an Alternate Delegate to the AMA. We are, therefore, pleased to nominate Dr. C. Douglass Ford as candidate for the office of President-Elect and are confident that he will provide outstanding leadership to the Ohio State Medical Association.

Respectfully submitted,
/s/Frank E. Foss, M.D.
President

Born in Columbus, Ohio, Dr. C. Douglass Ford received his bachelor's degree from Wesleyan University in Middletown, Connecticut before entering New York Medical College in New York, New York.

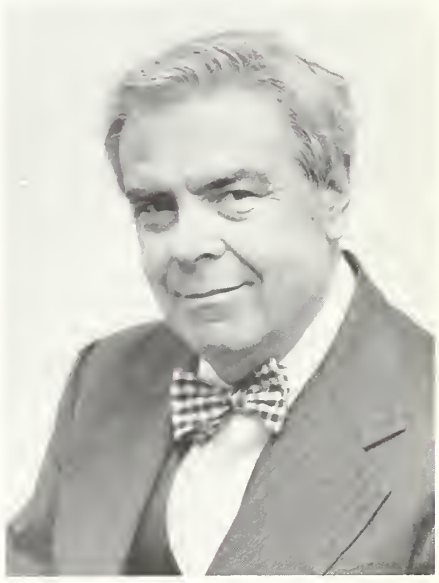
Following his graduation in 1949, he went on to serve a rotating internship in the U.S. Army, then took his residency at Toledo Hospital before settling into private practice as an internist in the Toledo area.

As a member of Toledo Hospital's medical staff since 1955, Dr. Ford has served 15 years, has served as Vice Chief of staff for four years, and has been director of the hospital's radioisotope laboratory for 25 years.

In addition to his practice and hospital duties, Dr. Ford is active in a number of community and medical organizations. He has served as clinical associate at the Medical College of Ohio for twelve years, and still serves on its Advisory Committee on Graduate Nursing Education. He is a member of the American Medical Association, the Society of Nuclear Medicine, the Ohio Society of Internal Medicine, the New York Academy of Sciences, and the Health Planning Association of Northwestern Ohio.

Dr. Ford is a past president of the American Heart Association of Northwestern Ohio, a former councilor of the Academy of Medicine of Toledo and Lucas County, and has served the Ohio State Medical Association in a number of capacities, including his present position as Councilor from the Fourth District, a post he has held since 1975.

He is married to the former Elizabeth (Betsy) Sargent, and has six children.



C. Douglass Ford, M.D.

Annual Meeting Format

Headquarters Hotel
Stouffer's Inn on the Square **(S)**
24 Public Square

Auxiliary Headquarters Hotel
Hollenden House **(H)**
E. Sixth & Superior

Bond Court Hotel (BC)
(Additional guest and meeting rooms)
E. Sixth at St. Clair Avenue

SATURDAY, MAY 16

Registration
8:00 AM
Sixth Floor, (BC)

Psychiatry
8:00 AM to 12:00 Noon
Council Meeting, Kaye (BC)
12:00 Noon to 2:00 PM
Luncheon, Rockefeller (BC)
2:00 PM to 5:00 PM
Scientific, Dolder (BC)

Team Building
8:30 AM to 4:30 PM
New York (S)
12:00 Noon
Luncheon, N. & S. Carolina (S)

You — The Telephone Manager
9:00 AM to 12:00 Noon
Owens (BC)

Improving English Pronunciation
9:00 AM to 5:00 PM
Georgia (S)
12:00 Noon
Luncheon, Pennsylvania (S)

Basic Life Support
1:00 PM to 5:00 PM
Classroom, Ritz (BC)
Workstation, Hope/Allen/Van Sweringen (BC)

The Doctor's Time and How to Schedule It (Office Personnel)
1:00 PM to 5:00 PM
Owens (BC)

Enhance Your Skills for Personal Financial Planning (for Physicians)
1:00 PM to 5:00 PM
Miller (BC)

SUNDAY, MAY 17

Course Registration
7:30 AM
Sixth Floor, (BC)

Advanced Life Support
8:00 AM to 5:00 PM
Classroom, Ritz (BC)
Workstations, Hope/Allen/Van Sweringen (BC)
12:00 Noon
Luncheon, Savoy (BC)

Home Town Interviews
All Day, Rhode Island and New Jersey (S)

Ohio Delegation to the AMA
2:00 PM to 4:00 PM
Prime Minister (S)

Art & Culture, Lounge & Resource Center
2:00 PM to 7:00 PM
Ambassador (S)

House of Delegates
3:00 PM to 7:00 PM
Registration
Ballroom Foyer (S)

5:30 PM to 7:00 PM
Dinner
Gold Room (S)

7:00 PM to 9:00 PM
First Session
Grand Ballroom (S)

Councilor District Caucuses
4:00 PM to 5:30 PM
(check suite locations at registration desk)

Wine & Cheese Party
(Sponsored by the Academy of Medicine of Cleveland)
After House of Delegates
Gold Room Assembly (S)

MONDAY, MAY 18

Reference Committee Breakfast
7:00 AM to 8:00 AM
Gold Room (S)

Reference Committee Meetings
7:30 AM to 2:00 PM
Res. Committee 1
N. Ballroom (S)
Res. Committee 2
S. Ballroom (S)
Res. Committee 3
Whitehall Room (S)
President's Address
Delaware (S)
Nominations
Pennsylvania (S)

Advanced Life Support (continued from Sunday)
8:00 AM to 5:00 PM
Classroom, Ritz (BC)
Workstations, Hope/Allen/Van Sweringen (BC)
12:00 Noon
Luncheon, Savoy (BC)

Registration
8:30 AM to 5:00 PM
Lobby Level, 2nd Floor (S)

Otolaryngology
8:45 AM to 4:30 PM
Meeting, Hassler (BC)
12:00 Noon
Luncheon, Dolder (BC)

Art & Culture, Lounge & Resource Center
9:00 AM to 4:00 PM
Ambassador (S)

Neurology
9:00 AM to 12:30 PM
Georgia (S)

Rheumatology
1:30 PM to 5:00 PM
Meeting, New York (S)
12:00 Noon
Luncheon Virginia (S)

Neurosurgical
2:00 PM to 4:00 PM
Business Meeting, Prime Minister (S)

Marketing & Competition
2:00 PM to 4:00 PM
Gold Room (S)

Ohio Medical Indemnity Reception
5:30 PM to 7:00 PM
Gold Room (S)

Medical Mutual Reception
5:00 PM to 7:00 PM
Versailles (S)

TUESDAY, MAY 19

Postgraduate Courses
7:30 AM to 10:30 AM
Electrolytes & Blood Gases, Hanna (BC)
Office Care for Older Persons, White (BC)
Drug Therapeutics, Allen (BC)

OMPAC Board Breakfast
8:00 AM to 11:00 AM
Versailles (S)

Ophthalmology
8:00 AM to 9:30 AM
Board of Governors Breakfast. New Hampshire (S)
9:30 AM to 11:15 AM, Business Meeting
1:30 PM to 5:00 PM, Scientific Meeting, Gold (S)

Registration
8:30 AM to 5:00 PM
Lobby Level, 2nd Floor (S)

Art & Culture, Lounge & Resource Center
9:00 AM to 4:00 PM
Ambassador (S)

Pfizer Dialogue
9:00 AM to 4:00 PM
Georgia (S)

Neurosurgical
9:00 AM to 4:00 PM
Meeting, Prime Minister (S)
12:00 Noon
Luncheon, Virginia (S)

Ohio Committee on Trauma, A.C.S.
9:00 AM to 11:30 AM
Hassler (BC)

Pathology
9:00 AM to 4:30 PM
New York (S)

Internal Medicine
9:00 AM to 12:00 Noon
Whitehall, (S)

Pediatrics
9:00 AM to 12:00 Noon
Meeting, North Carolina (S)
12:00 Noon to 1:00 PM
Luncheon, New Hampshire (S)

OMPAC Luncheon
11:30 AM to 2:00 PM
Grand Ballroom (S)

Physical Medicine & Rehabilitation
12:00 Noon to 1:30 PM
Luncheon, Savoy (BC)
1:30 PM to 4:00 PM
Meeting, Ritz (BC)

Emergency Medicine
2:00 PM to 5:00 PM
Hassler (BC)

OSMA Social Function
7:00 PM, Bus leaves hotel entrance at 6:30 PM
Frederick C. Crawford Museum

WEDNESDAY, MAY 20

Postgraduate Courses
7:30 AM to 10:30 AM
Non-Invasive Techniques, Hanna (BC)
Alcoholism, White (BC)

Registration
8:30 AM to 5:00 PM
Lobby Level, 2nd Floor (S)

General Practice
8:00 AM to 12:00 Noon
Whitehall Room (S)

Allergy & Immunology
8:30 AM to 11:30 AM
Meeting, Georgia (S)
12:00 Noon to 2:00 PM
Luncheon, New Hampshire (S)

Occupational Lung Disease
8:30 AM to 4:30 PM
Cleveland Clinic

Hospice Program
8:30 AM to 10:30 AM
North Carolina (S)

Sports Medicine
8:30 AM to 4:30 PM
Cleveland State University

Plastic Surgery
9:00 AM to 12:00 Noon
Meeting, New York (S)
12:15 PM
Luncheon, Virginia (S)

Art & Culture, Lounge & Resource Center
9:00 AM to 12:00 Noon
Ambassador (S)

Colon & Rectal Surgery
11:30 AM to 1:00 PM
Luncheon, Versailles (S)
1:00 PM to 5:00 PM
Meeting, Georgia (S)

OSMA Committee on Program
12:00 Noon
Luncheon/Meeting, Rhode Island (S)

PICO Program on Loss Awareness
1:30 PM to 2:30 PM
New York (S)

Anesthesiology
1:30 PM to 4:30 PM
Whitehall (S)

House of Delegates
2:30 PM to 3:30 PM
Registration
Ballroom Foyer (S)
3:30 PM to 6:00 PM
Final Business Session
Grand Ballroom (S)
6:00 PM
Dinner
Gold Room (S)

THURSDAY, MAY 21

OSMA Council Breakfast Meeting
8:30 AM to 10:00 AM
Versailles (S)

PICO Stockholders Meeting
10:00 AM
New York (S)

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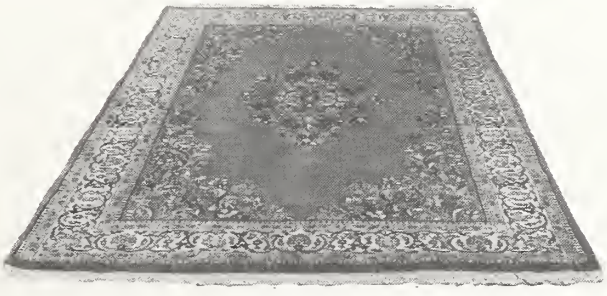
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Meeting Room Locations

In Stouffer's Inn on the Square

Lobby Level:
Ambassador Ballroom
Versailles Room

Mezzanine Level, Third Floor:
Grand Ballroom South
Grand Ballroom North
Grand Ballroom Assembly
Gold Room
Whitehall Room
VIP Room
Directors Room

Conference Level, Fourth Floor:
New York Room
Georgia Room
Rhode Island Room
New Jersey Room
Massachusetts Room
New Hampshire Room
North Carolina Room
South Carolina Room
Delaware Room
Virginia Room
Connecticut Room
Pennsylvania Room

Fifth Floor:
Prime Minister Suite
Viceroy Suite

In Bond Court Hotel

Sixth Floor:
Hassler Room
Savoy Room
Ritz Room
Dolder Room

Seventh Floor:
Hanna Room
White Room
Allen Room
Hope Room
Van Sweringen Room
Rockefeller Room
Owens Room
Miller Room
Newman Room
Kaye Room

Continuing Medical Education Courses

Postgraduate courses

Saturday May 16

Improving English Pronunciation

CME HOURS:
8 Category I

FEE:
$130 (luncheon included)

DATE:
Saturday, May 16 (one day)

PLACE:
Georgia Room, Stouffer's Inn on the Square

TIME:
9:00 AM - 5:00 PM

EQUIPMENT NEEDED:
Bring tape recorders

Course Description: An intensive one-day course on improving English pronunciation for foreign physicians. Participants should have a good working knowledge of English vocabulary and grammar.

The course will be taught by Elizabeth Lang, Professor of English as a second language, Cuyahoga Community College, Cleveland. Mrs. Lang has developed a study manual and cassette tapes for home study.

There will be lectures and practice on producing the sounds of general American English, intensive oral drill and criticism of individual students, and practice in sustained discourse through reading and extemporaneous speaking. The one-day program serves as a guide for further work at home with a 134-page study guide text and nine audio tapes.

Basic Life Support (CPR)

CME HOURS:
5 Category I

FEE:
$50

DATE:
Saturday, May 16 (half day)

PLACE:
Ritz Room, Bond Court Hotel

TIME:
1:00 - 5:00 PM

Course Description: A prerequisite for Advanced Cardiac Life Support Course. Certification in Basic Life Support is goal of this course.



You — The Telephone Manager

FEE:
$30

DATE:
Saturday, May 16 (half day)

PLACE:
Owens Room, Bond Court Hotel

TIME:
9:00 AM - 12:00 Noon

Course Description: To sharpen the medical assistant's interpersonal communication skills used daily in the office.

What you will learn:
- How to write a patient information booklet to improve patient relations and decrease routine phone calls
- How to save time on the telephone
- New telephone management approaches used by effective medical offices
- How to avoid medico-legal conflicts
- Learning how to handle difficult phone situations through the use of role-playing

Team Building (Physician's Office Supervisor)

FEE:
$60 (luncheon included)

DATE:
Saturday, May 16 (one day)

PLACE:
New York Room, Stouffer's Inn on the Square

TIME:
8:30 AM - 4:30 PM

Course Description: To sharpen the supervisory skills the medical office manager needs to develop and manage the office team.

What you will learn:
- How to recruit and interview candidates for your practice
- How to develop meaningful job descriptions
- How to organize an effective staff meeting
- How to design personnel policies and training methods to motivate staff
- How to conduct job performance evaluations
- Case studies and discussion make this a lively workshop and a "must" for every physician's "co-captain"

Doctor's Time and How To Schedule It (Office Personnel)

FEE:
$50

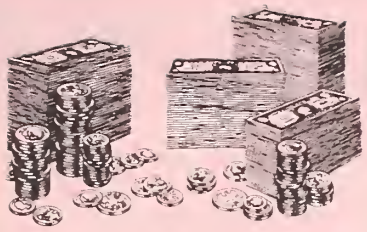
DATE:
Saturday, May 16 (half day)

PLACE:
Owens Room, Bond Court Hotel

TIME:
1:00 - 5:00 PM

Course Description: To assist the medical assistant in a step-by-step analysis of the present office appointment system and to implement the newest types of appointment designs.

What you will learn:
- How to minimize patient waiting time and maximize doctor time with patients
- How to effectively handle work-ins, no-shows, and walk-ins and other regular interruptions
- How to manage call-backs
- How to design a proven reminder and recall system
- How to schedule appointments with referral sources, lab, x-ray, surgical, and hospitals
- How to develop a customized appointment book



Personal Financial Planning (For Physicians)

FEE:
$50

DATE:
Saturday, May 16 (half day)

PLACE:
Miller Room, Bond Court Hotel

TIME:
1:00 - 5:00 PM

Course Description: To introduce physicians and their spouses to the tools and concepts needed to make sound financial decisions.

What you will learn:
- The newest techniques of budgeting used by professional personal financial planners
- How to understand the securities, bond, and option markets to formulate successful investment strategies
- Determine exactly how much and what type insurance you really need
- How to invest in the real estate market — understanding the components of a good deal
- Understanding the basic principles of successful tax and estate planning

How do you manage anorectal barbed fire?

95% of colon/rectal surgeons surveyed* add TUCKS® pads concomitantly to preferred suppository/ ointment/cream medication for best results...

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Please see following page for full prescribing information.

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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

PD-400-JA-0146-P-1 (1-81)

TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads
Hemorrhoids and other anorectal uses–TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witchhazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.
Vaginal Uses–Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
1089G010

PARKE-DAVIS
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Morris Plains, NJ 07950 USA

Sunday May 17

Advanced Life Support (CPR) (Two-day Course)

CME HOURS:
14 Category I

FEE:
$140 (luncheons included)

DATE:
Sunday, May 17 and Monday, May 18 (two-day)

PLACE:
Ritz Room, Bond Court Hotel

TIME:
8:00 AM - 5:00 PM

IMPORTANT:
Must be registered by April 20 — no late registrants

Course Description: Certification in Basic Life Support a prerequisite. Registrants will be certified according to standards of American Heart Association. The Northeast Ohio Affiliate, Inc. will provide course directors and faculty. Please register by April 20. No registrants for this course after this date.

Monday May 18

MARKETING AND COMPETITION

CME Hours:
2 Category I

Date:
Monday, May 18

Place:
Gold Room, Stouffer's Inn on the Square

Time:
2:00 PM to 4:00 PM

Sponsor:
OSMA Department of Communications

Competition. It works in the business world, but does it work in medicine — or should it? And what will it mean for physicians?

Competition in health care is increasingly being touted as the answer to everything from supply of physicians to control of health costs.



Roger Blackwell, Ph.D.

But just how does competition in medicine work and how will it affect the ways in which physicians deliver care?

For the past several months, the OSMA Committee on Communications has been studying these and other questions concerning marketing and competition in health care.

At a special session on Monday, May 18, Roger Blackwell, Ph.D., professor of marketing at the Ohio State University and consultant to the OSMA, will discuss his findings and offer valuable insight into the world of competition in health and its implications for physicians.

Tuesday May 19

Drug Therapeutics

CME HOURS:
3 Category I

FEE:
$30 (continental breakfast included)

DATE:
Tuesday, May 19

PLACE:
Allen Room, Bond Court Hotel

TIME:
7:30 AM - 10:30 AM

Electrolytes and Blood Gases

CME HOURS:
3 Category I

FEE:
$30 (continental breakfast included)

DATE:
Tuesday, May 19

PLACE:
Hanna Room, Bond Court Hotel

TIME:
7:30 AM - 10:30 AM

Wednesday May 20

Non-Invasive Techniques

CME HOURS:
3 Category I

FEE:
$30 (continental breakfast included)

DATE:
Wednesday, May 20

PLACE:
Hanna Room, Bond Court Hotel

TIME:
7:30 - 10:30 AM

Hotel Locations:
Stouffer's Inn on the Square
24 Public Square
Cleveland, Ohio 44113

Bond Court Hotel
E. Sixth at St. Clair Avenue
Cleveland, Ohio 44114

PICO PROGRAM ON LOSS AWARENESS

Date:
Wednesday, May 20

Place:
New York Room, Stouffer's Inn on the Square

Time:
1:30 PM to 2:30 PM

Sponsor:
Physician's Insurance Company of Ohio

PICO will present results of a recent study examining its loss experience — how the data can be interpreted for Ohio physicians, for PICO, and for the medical professional liability market as a whole. The presenters will also discuss how to minimize the possibility of a suit, how a physician should react to a claim, and courtroom behavior. Presenters will be PICO physician board members, professional staff, and PICO legal counsel.

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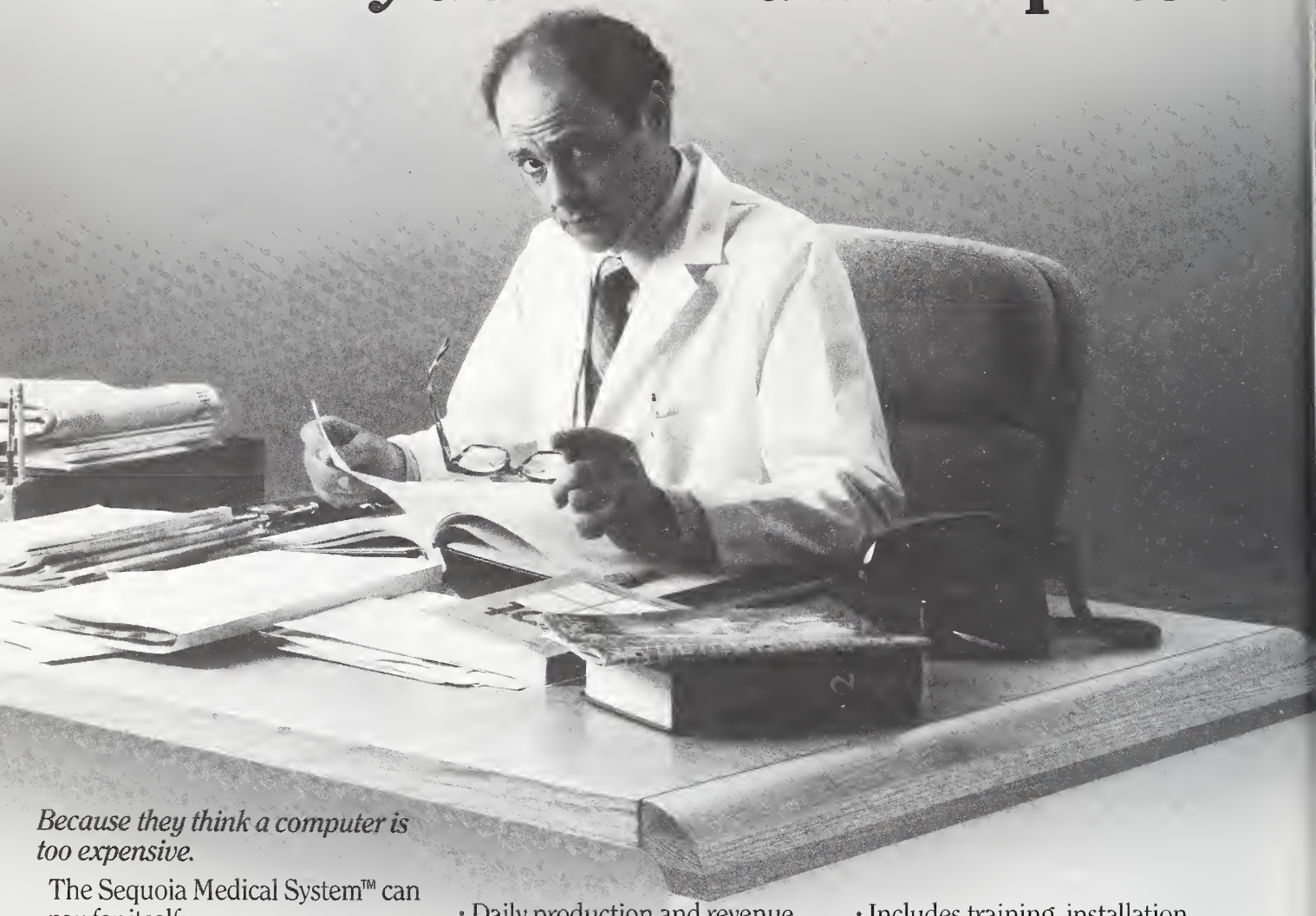
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Local offices in Ohio: Columbus, (614) 866-2818; Beachwood, (216) 292-7056

Wednesday May 20

(continued)

Chemical Dependency — consultant

CME HOURS:
3 Category I

FEE:
$30 (continental breakfast included)

DATE:
Wednesday, May 20

PLACE:
White Room, Bond Court Hotel

TIME:
7:30 - 10:30 AM

HOSPICE PROGRAM

Topic:
Hospice Care: The Concept and Its Implementation in Ohio

Date:
Wednesday, May 20

Place:
North Carolina Room, Stouffer's Inn on the Square

Time:
8:30 AM to 10:30 AM

Sponsor:
Hospice Council for Northern Ohio

Keynote Speaker:
Andrew Adams, M.D., Medical Director, Our Lady of Lourdes Hospital Hospice Program, Bingington, New York

Moderator:
Paul Zeit, M.D., Chairperson, Medical Advisory Committee, Hospice Council for Northern Ohio, Burton

Objectives:
To provide a forum for an exchange of ideas among medical directors from the numerous hospice programs in Ohio.

To disseminate information about hospice care to physicians interested in utilizing hospice programs throughout the state.

Format:
During this session there will be an informal presentation about hospice programs that are available in Ohio, the role of the medical director and the problems encountered in patient/family care. All hospice medical directors are urged to attend and share their experiences. In addition, physicians who are interested in utilizing hospice programs will receive information on the basic concepts of care as well as have an opportunity to ask questions about individual programs, eligibility, admission procedures, costs, etc.

Saturday May 16

Specialty Section Programs

PSYCHIATRY

CME Hours:
3 Category I

Date:
Saturday, May 16

Place:
Council Meeting — Kaye Room, Bond Court Hotel
Luncheon — Rockefeller Room, Bond Court Hotel
Scientific — Dolder Room, Bond Court Hotel

Time:
8:00 AM to 5:00 PM

Sponsor:
Ohio Psychiatric Association and OSMA Section on Psychiatry and Neurology

Schedule:

8:00 AM
Council Meeting
Kaye Room, Bond Court Hotel

12:00 Noon
Luncheon
Rockefeller Room, Bond Court Hotel

2:00 PM
To Watch and Be Watched: The Plight of a Therapist
Monique B. King, M.D., Cleveland Heights

2:30 PM
Questions and Answers

2:40 PM
Utilization Review by the Third-Party Carrier
Eleanor Havens, R.N., Cleveland, and
John Sawyer, M.D., Cleveland,
Robert Frymier, M.D., Cleveland

3:00 PM
Questions and Answers

3:10 PM
Coffee Break

3:45 PM
Quality Assurance — "if only I could see to read this thermometer"
Daniel A. Deutschman, M.D., Cleveland

4:05 PM
Questions and Answers

4:15 PM
Panel

Monday May 18

TRAUMA

Topic:
Management of Common Emergency Room Problems

CME Hours:
3 Category I

Date:
Tuesday, May 19

Place:
Hassler Room, Bond Court Hotel

Time:
9:00 AM to 12:00 Noon

Sponsor:
Ohio Committee on Trauma, A.C.S.

Course Director:
Richard B. Fratianne, M.D., Chairman Ohio Committee on Trauma, A.C.S., Cleveland

Schedule:
9:00 AM
Coffee

9:20 AM
ENT Emergencies
Anton Milo, M.D., Akron

10:00 AM
Management of Facial Wounds With and Without Tissue Loss
John Robinson, M.D., Toledo

10:40 AM
Injuries of the Eye
Mark R. Levine, M.D., Cleveland

11:00 AM
Head Trauma and Spinal Cord Injuries
Dennis Kopaniky, M.D., Cleveland

PHYSICAL MEDICINE

CME Hours:
2 Category I

Date:
Tuesday, May 19

Place:
Ritz Room, Bond Court Hotel

Time:
1:30 PM to 4:00 PM

Sponsor:
OSMA Section on Physical Medicine and Rehabilitation and Ohio Society of Physical Medicine and Rehabilitation

Schedule:
12:00 Noon
Luncheon and business meeting
Savoy Room, Bond Court Hotel

1:30 PM
Behavior Modification in Chronic Back Pain I
W. E. Fordyce, Ph.D., Professor of Psychology, Department of Rehabilitation and Medicine Pain Clinic; University of Washington, Seattle, Washington

2:45 PM
Coffee Break

3:15 PM
Behavior Modification in Chronic Back Pain II, discussion with audience
W. E. Fordyce, Ph.D.

NEUROLOGY

CME Hours:
3½ Category I

Date:
Monday, May 18

Place:
Georgia Room, Stouffer's Inn on the Square

Time:
9:00 AM to 12:30 PM

Sponsor:
OSMA Section on Neurology

Schedule:
9:00 AM
Welcome

9:05 AM
New Diagnostic Techniques in Cerebrovascular Disease
Anthony Furlan, M.D., Head, Section of Cerebrovascular Disease Department of Neurology, Cleveland Clinic, Cleveland

9:35 AM
Nystagmus, 1981
Robert B. Daroff, M.D., Chairman, Department of Neurology, Case Western Reserve School of Medicine, Cleveland

10:05 AM
Practical Points in Managing Acute Peripheral Nerve Injuries
Asa Wilbourn, M.D., Head, Section of Electromyography, Cleveland Clinic, Cleveland

10:35 AM
Question and Answer Period

Break

11:00 AM
Why Neurologists Get Sued and What They Can Do About It
John Irwin, Attorney at Law, Legal Department, Cleveland Clinic, Cleveland

11:20 AM
Anatomical Basis of Memory
Maurice Victor, M.D., Director, Division of Neurology, Cleveland Metropolitan Hospital, Cleveland

12:05 PM
Question and Answer Period

12:30 PM
Adjournment

Tuesday May 19

EMERGENCY MEDICINE

Topic:
PRIMER For Emergency Radio Communication Between the Physician and the Paramedic

CME Hours:
3 Category I

Date:
Tuesday, May 19

Place:
Hassler Room, Bond Court Hotel

Time:
2:00 PM to 5:00 PM

Sponsor:
Ohio Chapter — American College of Emergency Physicians

Course Director:
Thomas J. Hall, M.D., Member-Board of Directors, Ohio Chapter, American College of Emergency Physicians, Newark

Presiding Officer:
Michael Ervin, M.D., Miami Valley Hospital, Dayton

Schedule

2:00 PM
Introduction
Thomas J. Hall, M.D.

2:45 PM
Break

3:00 PM
Case Studies and Discussions
Thomas J. Hall, M.D., Moderator
Discussants to be announced.

4:00 PM
Break

4:15 PM
Questions and Answers

INTERNAL MEDICINE

CME Hours:
3 Category I

Date:
Tuesday, May 19

Place:
Whitehall Room, Stouffer's Inn on the Square

Time:
9:00 AM to 12:00 Noon

Sponsor:
OSMA Section on Internal Medicine and the Ohio Society of Internal Medicine

Moderator:
William Sheldon, M.D., Chairman, Department of Cardiology, Cleveland Clinic Foundation, Cleveland

Schedule:

9:00 AM
Clinical Recognition of Coronary Heart Disease
James Hodgman, M.D., Cleveland Clinic, Cleveland

9:15 AM
Non-Invasive Technics in the Evaluation of Coronary Heart Disease
Neil Hart, M.D., Cleveland Clinic, Cleveland

9:30 AM
Coronary Arteriography
Fred Heupler, M.D., Cleveland Clinic, Cleveland

9:45 AM
Discussion

10:15 AM
Coffee Break

10:45 AM
Progression of Coronary Atherosclerosis
John Kramer, M.D., Cleveland Clinic, Cleveland

11:00 AM
Percutaneous Transluminal Coronary Artery Dilatation
Dan Phillips, M.D., Cleveland Clinic, Cleveland

11:15 AM
Surgical Treatment of Coronary Artery Disease
Delos Cosgrove, M.D., Cleveland Clinic, Cleveland

11:30 AM
Discussion

PEDIATRICS

Date:
Tuesday, May 19

Place:
North Carolina Room, Stouffer's Inn on the Square

Time:
9:00 AM to 12:00 Noon

Sponsor:
Ohio Chapter, American Academy of Pediatrics

Program Director:
Leonard P. Rome, M.D., Cleveland, Chairman, Ohio Chapter, American Academy of Pediatrics

Program Description:
Executive Committee, Ohio Chapter, American Academy of Pediatrics. Open discussion will include: GMENAC, Ohio Commission for Children, National Child Health Goal, Pediatric Emergency Medicine, Ohio Perinatal Guidelines, Health Manpower Survey, Child Daycare Centers, and Newborn Screening Programs.

12:00 Noon
Luncheon
New Hampshire Room, Stouffer's Inn on the Square

Tuesday May 19

(continued)

PATHOLOGY

CME Hours:
5 Category I

Date:
Tuesday, May 19

Place:
New York Room, Stouffer's Inn on the Square

Time:
9:00 AM to 4:30 PM

Sponsor:
OSMA Section on Pathology and the Ohio Society of Pathologists

Schedule:

9:00 AM
Welcome
George Hoffman, M.D., President, Ohio Society of Pathologists, Cleveland

9:05 AM
Needle Aspiration Biopsy of the Breast
Bruce Sebek, M.D., Department of Anatomic Pathology, Cleveland Clinic, Cleveland

10:00 AM
Break

10:30 AM
Estrogen and Progesterone Receptor Assays in Breast Cancer — Clinical Aspects

11:00 AM
Estrogen and Progesterone Receptor Assays in Breast Cancer — Technical Aspects

11:30 AM
Business Meeting, Ohio Society of Pathologists

12:30 PM
Luncheon

1:30 PM
Seminar — Diseases of the Breast
Harold A. Oberman, M.D. Professor of Pathology, University of Michigan Medical School, Ann Arbor, Michigan

3:00 PM
Break

3:20 PM
Seminar — Diseases of the Breast (continued)

4:30 PM
Adjournment

OPHTHALMOLOGY

Topic:
Ocular Manifestations of Systemic Disease

CME Hours:
4 Category I

Date:
Tuesday, May 19

Place:
Gold Room, Stouffer's Inn on the Square

Time:
1:30 PM to 5:00 PM (Scientific Session)

Sponsor:
OSMA Section on Ophthalmology and the Ohio Ophthalmological Society

Board of Governors Breakfast:
8:00 AM to 9:30 AM
New Hampshire Room, Stouffer's Inn on the Square

9:30 AM to 11:15 AM
Business Meeting
Gold Room, Stouffer's Inn on the Square

Faculty:
John Bullock, M.D., Dayton
Carl Ellenberger, M.D., Cleveland
Stuart Fine, M.D., Baltimore, Maryland
Sterling Haidt, M.D., Cincinnati
Carol Kollarits, M.D., Toledo
Torrence Makley, M.D., Columbus
Daniel Marcus, M.D., Toledo
Lawrence Singerman, M.D., Cleveland
Robert Tomsak, M.D., Cleveland
Arden Wander, M.D., Cincinnati
Frank Weinstock, M.D., Canton

RHEUMATOLOGY

CME Hours:
3 Category I

Place:
New York Room, Stouffer's Inn on the Square

Time:
1:30 PM to 5:00 PM

Sponsor:
Ohio Rheumatism Society and OSMA Section on Rheumatology

Course Director:
Waldemar Bergen, M.D., Clinical Assistant Professor, Ohio State University, College of Medicine, Columbus; Program Chairman, Ohio Rheumatism Society and OSMA Section on Rheumatology

Schedule:

12:00 Noon
Luncheon Meeting, Members of the Ohio Rheumatism Society
Virginia Room, Stouffer's Inn on the Square

1:30 PM
Introduction

1:40 PM
Polymyalgia Rheumatica and Giant Cell Arteritis
Gene G. Hunder, M.D., Professor of Medicine, Mayo Medical School, Rochester, Minnesota.

2:30 PM
Immune Complexes — Clinical Significance
John D. Clough, M.D., Chairman, Department of Rheumatic and Immunological Diseases, Cleveland Clinic, Cleveland

3:00 PM
Break

3:30 PM
Systemic Manifestations of Rheumatoid Arthritis
Vol K. Philips, M.D., Clinical Associate Professor, Ohio State University, College of Medicine, Columbus

4:00 PM
Nuclear Scanning in Rheumatic Diseases
Thomas C. Namey, M.D., Associate Professor of Medicine and Radiology, Chief, Division of Rheumatic Diseases, Medical College of Ohio, Toledo

4:30 PM
Panel Discussion

5:00 PM
Adjournment

OTOLARYNGOLOGY

CME Hours:
6 Category I

Date:
Monday, May 18

Place:
Hassler Room, Bond Court Hotel

Time:
8:45 AM to 4:30 PM

Sponsor:
OSMA Section on Otolaryngology and the Ohio Society of Otolaryngology

Schedule:

8:45 AM
Welcome
Alan J. Sogg, M.D., President, Ohio Society of Otolaryngology, Maple Heights

8:55 AM
Introduction of Speakers and Program
Don E. Gebhart, M.D., Program Director, OSMA Section on Otolaryngology and the Ohio Society of Otolaryngology, Columbus

Laryngeal Rehabilitation Following Total Laryngectomy

9:00 AM
Experience with the Staffieri Procedure
Jack L. Gluckman, M.D., Assistant Professor & Director, Division of Head and Neck Surgery, Department of Otolaryngology & Maxillofacial Surgery, University of Cincinnati, Cincinnati

9:30 AM
Experience with the "Duck-Bill" Prosthesis
Benjamin G. Wood, M.D., Department of Otolaryngology and Communicative Disorders, Cleveland Clinic, Cleveland, and *Ms. Melinda Rusnov*, Speech Pathologist, Cleveland Clinic, Cleveland

10:15 AM
Coffee Break

10:45 AM
Retropharyngeal Voice Box for Vocal Restoration Following Total Laryngectomy
Guy LaFond, M.D., University of Toronto Medical Sciences Building, Toronto, Ontario, Canada

11:15 AM
Panel Discussion on Laryngeal Rehabilitation
Harvey Tucker, M.D., Chairman, Department of Otolaryngology and Communicative Disorders, Cleveland Clinic, Cleveland

Panel Members: *Jack L. Gluckman, M.D., Benjamin G. Wood, M.D., Guy LaFond, M.D.*, and *Melinda Rusnov.*

12:00 Noon
Luncheon/Business Meeting
Dolder Room, Bond Court Hotel

1:30 PM
What You Always Wanted to Know About Rhinoplasty But Were Afraid to Ask
Trent Smith, M.D., Clinical Professor of Otolaryngology, Ohio State University, Columbus, and *Wynn Smith, M.D.*, Columbus

2:30 PM
Technique of Blepharoplasty
Trent Smith, M.D.

3:00 PM
Coffee Break

3:30 PM
Technique of Segmental Face Lift, a video tape presentation
Trent Smith, M.D.

4:30 PM
Adjournment

NEUROSURGERY

Topic:
Symposium on Aneurysm Surgery

CME Hours:
6 Category I

Date:
Tuesday, May 19

Place:
Prime Minister Room, Stouffer's Inn on the Square

Time:
9:00 AM to 4:00 PM

Sponsor:
OSMA Section on Neurosurgery and the Ohio State Neurosurgical Society

Schedule:

9:00 AM
The Timing of Aneurysm Surgery and Preoperative Management
William Hunt, M.D., University Hospital, Columbus

9:30 AM
Discussion

9:40 AM
Vasospasm: Basic Mechanisms and Possible Treatments
Nicholas Zervas, M.D., Professor of Surgery, Harvard Medical School, Boston, Massachusetts

10:10 AM
Discussion

10:20 AM
Coffee Break

10:40 AM
Techniques of Aneurysm Surgery
John Tew, M.D., Director, Graduate Education Program in Neurological Surgery, Good Samaritan Hospital, Cincinnati

11:10 AM
Discussion

11:20 AM
Results of Aneurysm Surgery
Donald Dohn, M.D., Head, Department of Neurological Surgery, Cleveland Clinic Foundation, Cleveland

11:50 AM
Discussion

12:00 Noon
Luncheon
Virginia Room, Stouffer's Inn on the Square

1:30 PM
Afternoon portion of the program not complete at time of publication

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Wednesday May 20

ALLERGY AND IMMUNOLOGY

CME Hours:
3 Category I

Date:
Wednesday, May 20

Place:
Georgia Room, Stouffer's Inn on the Square

Time:
8:30 AM to 12:30 PM

Sponsor:
OSMA Section on Allergy and Immunology and Ohio Society of Allergy and Immunology

Schedule

8:30 PM
Use of Non-Theophylline Drugs in Asthma
Thomas J. Fischer, M.D.
Assistant Professor of Pediatrics; Director, Division of Allergy/Immunology, Children's Hospital Medical Center, Cincinnati

9:15 AM
Practical Antihistamine Approach
Edward Hine, M.D.
Cleveland Clinic, Cleveland

10:00 AM
Coffee Break

10:20 AM
Modern Reconstruction of Immunodeficiency
Richard Hong, M.D. University Hospital, Madison, Wisconsin

11:20 AM
Panel Discussion — questions

12:30 PM
Business Meeting & Luncheon
New Hampshire Room, Stouffer's Inn on the Square

ANESTHESIOLOGY

CME Hours:
3 Category I

Date:
Wednesday, May 20

Place:
Whitehall Room, Stouffer's Inn on the Square

Time:
1:30 PM to 4:30 PM

Sponsor:
Ohio Society of Anesthesiologists, Inc. and OSMA Section on Anesthesiology

Moderator:
John L. Zintsmaster, M.D., Tallmadge

Schedule

1:30 PM
Sleep Apnea
Milton Kramer, M.D., Director, Sleep Laboratory, University of Cincinnati, Cincinnati

2:30 PM
Question and Answer Period

2:50 PM
Coffee Break

3:10 PM
Normal and Abnormal Sleep
Robert Clark, M.D., Assistant Director, Ohio State University Sleep Disorders Evaluation Center, Columbus

4:10 PM
Question and Answer Period

SPORTS MEDICINE

Date:
Wednesday, May 20

Place:
Cleveland State University

Time:
8:30 AM to 4:30 PM

Schedule:

8:30 AM
Prevention of Injuries
Overview — *Tom McLaughlin, M.D.*, Cleveland
Noncontact Injuries — *Ted Georgeff, A.T.C.*, Head Athletic Trainer, Capital University, Columbus
Contact Injuries — *Bill Tessendorf, A.T.C.*, Baldwin-Wallace College, Berea

9:10 AM
Head and Neck Injuries
Garron Weiker, M.D., Department of Orthopaedic Surgery, Cleveland Clinic, Cleveland

9:30 AM
Field Decisions and Management of Acute Injuries
Upper Extremities — *John Bergfeld, M.D.*, Department of Orthopaedic Surgery, Cleveland Clinic, Cleveland, and *Jack McNeeley, A.T.C.*, Cleveland State University, Cleveland
Lower Extremities — *Kenneth W. Chapman, M.D.*, Cleveland and *Crick Wellman, A.T.C.*, Baldwin-Wallace College Athletic Department, Berea

11:15 AM
Panel

12:00 Noon
Lunch

1:30 PM
Heat Stress
Jack Andrish, M.D., Department of Orthopaedic Surgery, Cleveland Clinic, Cleveland, and *Paul Spicuzzi, A.T.C.*, Mentor

2:00 PM
Rehabilitation
Lynn Wallace, A.T.C., P.T., Western Reserve Therapist, Inc., Chesterland, and *Jim Long, P.T.*, Department of Orthopaedic Surgery, Cleveland Clinic, Cleveland

2:45 PM
Coach-Trainer Relationship
Leo Murphy, Trainer, Baldwin-Wallace College, Berea

3:15 PM
Panel

COLON AND RECTAL SURGERY

CME Hours:
4 Category I

Date:
Wednesday, May 20

Place:
Georgia Room, Stouffer's Inn on the Square

Time:
1:00 PM to 5:00 PM

Sponsor:
OSMA Section on Colon and Rectal Surgery

Luncheon:
11:30 AM
Versailles Room, Stouffer's Inn on the Square

Schedule

1:10 PM
Diagnosis and Treatment of Familial Polyposis and Ulcerative Colitis
Lester Martin, M.D., Professor & Chairman, Department of Pediatric Surgery, Children's Hospital, Cincinnati

1:25 PM
Treatment of Inflammatory Bowel Disease
Thomas G. Hardy, Jr., M.D., Columbus

1:45 PM
Abdominal Perineal Resection and Its Alternatives for Carcinoma of the Rectum
Frank L. Weakley, M.D., Staff Surgeon, Department of Colon & Rectal Surgery, The Cleveland Clinic, Cleveland

1:55 PM
Elective Resection for Diverticular Disease
W. Patrick Mazier, M.D., Ferguson Clinic, Grand Rapids, Michigan

2:15 PM
CEA (carcinoembryonic antigen) for Diagnosis and Treatment of Recurrent Carcinoma of the Colon
Edward W. Martin, Jr., M.D., Assistant Professor in the Department of Surgery, Ohio State University, Columbus

2:25 PM
Topic to be announced
Patrick F. Hagihara, M.D., University of Kentucky, Lexington, Kentucky

2:40 PM
Break

3:00 PM
Anorectal Problems in Pediatric Surgery
Lester Martin, M.D.,

3:15 PM
Problems in Anorectal Surgery in Adults
W. Patrick Mazier, M.D.,

3:30 PM
Polyps, Polyposis and Polypoid Diseases
David G. Jagelman, M.D., Staff Surgeon, Department of Colon-Rectal Surgery, Cleveland Clinic Foundation, Cleveland

3:35 PM
Panel Discussion
Moderator: *Ralph B. Samson, M.D.*, Clinical Associate Professor, Ohio State University, Columbus

5:00 PM
Adjournment

OCCUPATIONAL LUNG DISEASE

Topic:
Occupational Lung Problems — Update 1981

CME Hours:
6 Category I

Date:
Wednesday, May 20

Place:
Cleveland Clinic

Time:
8:00 AM to 5:00 PM

Course Director:
H. S. VanOrdstrand, M.D., Cleveland Heights

This will be a one-day teaching program requested by our Ohio State Industrial Commission, and co-sponsored by the Cleveland Clinic Educational Foundation and our Ohio State Medical Association. It will also serve as the Chest section specialty meeting of our Annual Ohio State Medical Association Scientific Program being held in Cleveland at that time. It will meet the requirements of Category I credit.

The course will consist of presentations with panel discussions and audience participation in the most frequent current respiratory health problems with workers, including the subjects of asthma and emphysema (chronic obstructive lung disease), pulmonary fibrosis, lung cancer, chemicals, dusts and fibers. The faculty of Environmental Lung Specialists, chosen by their peers to give the facts of our present state of knowledge on the subjects, will include out-of-state speakers, Dr. Keith Morgan of London, Ontario (the senior author of the current comprehensive book entitled "Occupational Lung Diseases"), Dr. Edward Gaensler of Boston University School of Medicine, and Dr. David Parkinson of the Pittsburgh University Medical School.

The seminar is intended to be an educational experience to all involved in workers' problems, including hearing officers, law judges, industrial hygienists, claimants and defense attorneys, as well as the family and neighborhood physicians, and all lung specialists (including those serving the Industrial Commission as consultants).

Advance registration information can be obtained by calling Mrs. Post at the Cleveland Clinic — (216) 444-5696.

GENERAL PRACTICE

Topic:
Critically Ill Patient from Pulmonary Standpoint

CME Hours:
2 Category I

Date:
Wednesday, May 20

Place:
Whitehall Room, Stouffer's Inn on the Square

Time:
10:00 AM to 12:00 Noon

Sponsor:
Ohio Academy of Family Physicians and OSMA Section on Family Practice

Speakers:
Timothy Tuthill, M.D., Case Western Reserve University, Cleveland

Lawrence Martin, M.D., Case Western Reserve University, Cleveland

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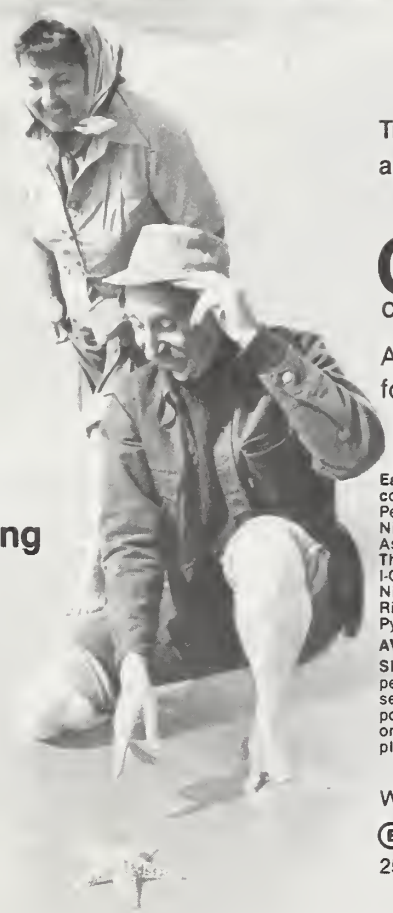
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PFIZER DIALOGUE PRESENTATIONS

CME Hours:
1 Category I (each presentation)

Date:
Tuesday, May 19

Fee:
None

Place:
Georgia Room, Stouffer's Inn on the Square

Time:
As designated

Sponsor:
OSMA Committee on Program in cooperation with Pfizer Pharmaceuticals

Schedule:

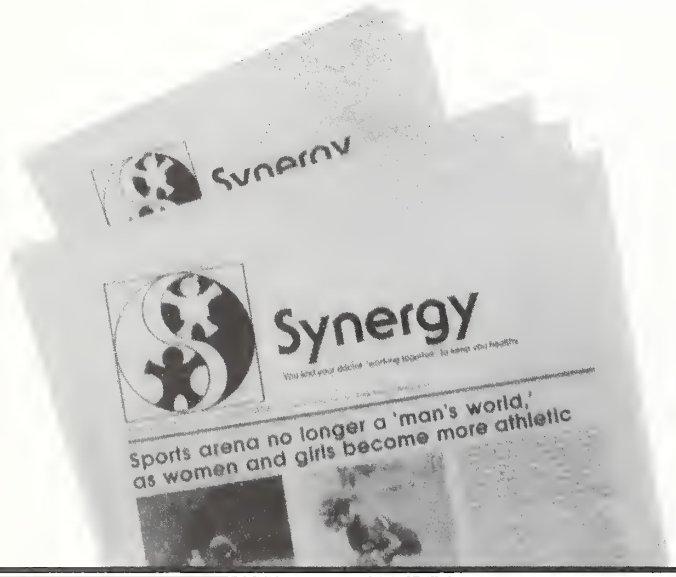
9:00 AM
Current Concepts in the Treatment of Diabetes Mellitus
Samuel Cataland, M.D., Professor of Medicine, Associate Director, Clinical Research, Division of Endocrinology, Ohio State University Hospital, Columbus

11:00 AM
Rational Use of Psychotropic Drugs in the Middle-Age Patient
Fred Charatan, M.D., Chief of Psychiatry, Jewish Institute for Geriatric Care, New Hyde Park, Associate Professor of Clinical Psychiatry, State University of New York, Stonybrook, New York

1:00 PM
Anesthesia and Its Effect on the Newborn
Ezzat Abouleish, M.D., Director of Obstetrical Anesthesia Magee-Womens Hospital, Professor of Anesthesiology, University of Pittsburgh, Pittsburgh, Pennsylvania

2:15 PM
Film: The Role of Calcium Inhibition in the Management of Ischemic Heart Disease

3:00 PM
Management of the Hypertensive Patient
Donald G. Vidt, M.D., Head, Clinic Section, Department of Hypertension and Nephrology, Cleveland Clinic Foundation, Cleveland



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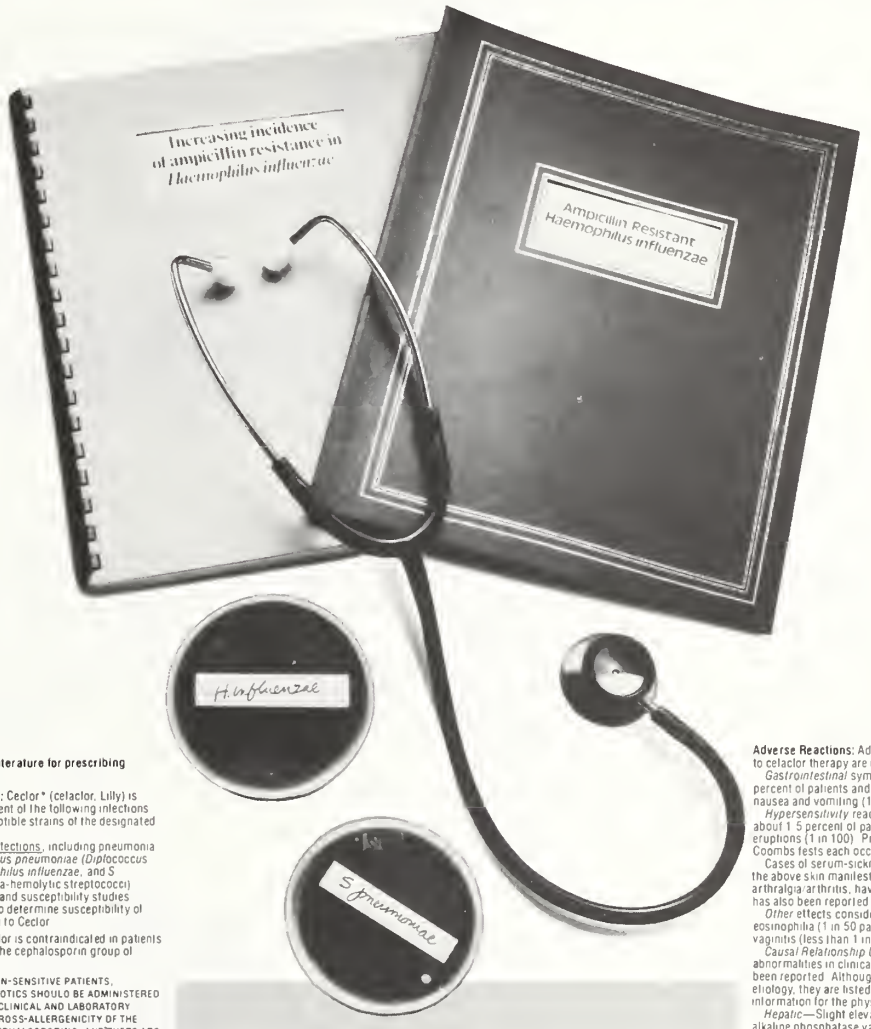
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In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*: 91, 1975
2. Antimicrob. Agents Chemother., *11*: 470, 1977
3. Antimicrob. Agents Chemother., *13*: 584, 1978
4. Antimicrob. Agents Chemother., *12*: 490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., *13*: 861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[103080R]

OMPAC Luncheon

FEE:
$15 per person

DATE:
Tuesday, May 19

PLACE:
Grand Ballroom, Stouffer's Inn on the Square

TIME:
Social Period 11:30 AM followed by lunch at 12:00 Noon

Speaker: Roger E. Ailes, well-known TV producer and communications expert will share his unusual and innovative political television techniques, as one of the leading experts in political media on the scene today. During the past few years, Mr. Ailes has served as broadcast media consultant to many republican senatorial and gubernatorial candidates and officeholders.



Roger Ailes has been called an "advertising whiz," a "media consultant," and "one of the leading communications experts in this country," but perhaps it is his more colorful appellations, "The Man of Tomorrow," and "The Man Who Sold You Al's Mom and Mrs. Nixon's Son," which more accurately paint his picture. Besides his commercial success as a producer/director ("The Mike Douglas Show," the remodeled "Tomorrow Coast-to-Coast," and a score of Broadway and off-Broadway shows), Ailes also has been the creative force behind a number of politically successful campaigns. To reserve your space at the OMPAC Luncheon, please use the form on page 223.

OSMA and Auxiliary Social Function

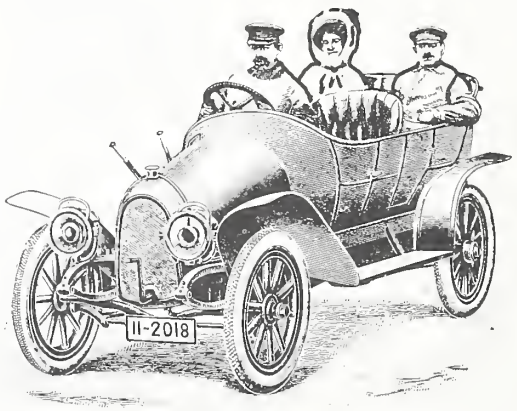
FEE:
$30 per person

DATE:
Tuesday, May 19

PLACE:
Frederick C. Crawford Auto-Aviation Museum
10825 East Blvd., Cleveland, Ohio

TIME:
Buses leave hotel entrance at 6:30 PM; Social Hour, 7:00 PM; Dinner, 8:00. Entertainment throughout evening.

Description: The Crawford Auto-Aviation Museum is a special kind of place. Here you discover the daring and adventure that were so much a part of the "horseless carriage" age, which have been preserved and exhibited with loving care.



Join your colleagues for an unforgettable party at the Frederick C. Crawford Auto-Aviation Museum. Guests will be surrounded by the history and nostalgia of the automobile and aircraft industry. The jewel-like setting, accented with the world's finest collection of historic automobiles and aircraft, creates an immediate air of excitement, in a grand manner.

A full evening of dinner and entertainment will be the order of business.

Bus service from hotel to Museum and return will be furnished. Check registration form for number of tickets and mail to OSMA with check today!

Ohio State Medical Association

1981 Annual Meeting

May 16-20, 1981 — **Cleveland, Ohio**

REGISTRATION FORM

Please register me for the following Annual Meeting activities:

Date - Activity	Fee
SATURDAY, MAY 16	
☐ Basic Life Support (CPR)	$ 50
☐ Doctor's Time and How to Schedule It (Office Personnel)	$ 50
☐ Improving English Pronunciation	$130
☐ Personal Financial Planning (for Physicians)	$ 50
☐ Team Building (Physician's Office Supervisor)	$ 60
☐ You — The Telephone Manager	$ 30
SUNDAY, MAY 17	
☐ Advanced Life Support (CPR) 2-day-continued on Monday	$140
TUESDAY, MAY 19	
☐ Drug Therapeutics	$ 30
☐ Electrolytes & Blood Gases	$ 30
☐ Office Care for Older Persons	$ 30
OMPAC Luncheon (No. of tickets ___)	$15/person
OSMA and Auxiliary Function (No. of tickets ___)	$30/person
WEDNESDAY, MAY 20	
☐ Chemical Dependency	$ 30
☐ Non-Invasive Techniques	$ 30
• ±	
TOTAL FEE DUE	

- Non-OSMA members (except medical students, residents, and retired physicians) please add $15 to total fee remittance.
- Medical students, residents, and retired physicians, please deduct 20% from total fee remittance (excepting OMPAC Luncheon and OSMA Social Function fees).

Payment must accompany registration form.
Make check payable to Ohio State Medical Association

Please type or print

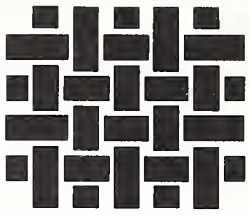
NAME _____ (Telephone No.)

ADDRESS _____ (Street) (City) (State) (Zip)

I am ☐ OSMA Member ☐ Non-Member Physician ☐ Physician-in-Training ☐ Medical Student ☐ Guest ☐ Other

☐ Please prepare guest badge for my spouse.

Mail form to: **Department of Education and Meeting Management**
Ohio State Medical Association
600 South High Street, Columbus, Ohio 43215



Members of 1981 OSMA House of Delegates

1st District

ADAMS COUNTY

Delegate:
Francis L. Stevens
Alternate:

BROWN COUNTY

Delegate:
John R. Donohoo
Alternate:
Gene F. Conway

BUTLER COUNTY

Delegates:
Marvin J. Rassell
James M. Smith
Alternates:
Jack L. Harris
Thomas T. Macejko
Michael A. Matthews

CLERMONT COUNTY

Delegate:
Carl A. Minning
Alternate:
Wm. Blake Selnick

CLINTON COUNTY

Delegate:
Wilhelm A. Kraeling
Alternate:
Edwin P. Hiatt

HAMILTON COUNTY

Delegates:
John E. Albers
Sanford Blank
Richard B. Budde
Harry H. Fox
Kenneth A. Frederick
William H. Gates
Robert S. Heidt
Harry K. Hines
Stephen P. Hogg
Stanley J. Lucas
Herbert G. Magenheim
Richard L. Meyer
Thomas U. Todd
Lee J. Vesper
Walter B. Wildman II
Alternates:
Harold Pescovitz
Donald I. Radin
John L. Thinnes
John H. Wulsin

HIGHLAND COUNTY

Delegate:
Glenn B. Doan
Alternate:

WARREN COUNTY

Delegate:
Thomas E. Fox
Alternate:

2nd District

CHAMPAIGN COUNTY

Delegate:
John H. Flora
Alternate:
Steven Polsley

CLARK COUNTY

Delegates:
Henry A. Diederichs
Ernest H. Winterhoff
Alternates:
William Harper
Walter Lawrence

DARKE COUNTY

Delegate:
William S. Elliott
Alternate:
Alvan E. Thuma

GREENE COUNTY

Delegate:
R. William Barry
Alternate:
Justin G. Krause

MIAMI COUNTY

Delegate:
A. Robert Davies
Alternate:
Jerry L. Hammon

MONTGOMERY COUNTY

Delegates:
Herman I. Abromowitz
R. Alan Baker
D. Kiefer Campbell
Robert K. Finley, Jr.
Richard G. Jenkins
Frederic C. Schnebly
John R. Whitaker, Jr.
Alternates:
Gerald J. Broock
Gilbert W. Hopkins
Stephen T. House
Sidney F. Miller
Kenneth P. Pohl
Walter A. Reiling, Jr.
Gilbert W. Templeton

PREBLE COUNTY

Delegate:
John D. Darrow
Alternate:

SHELBY COUNTY

Delegate:
George J. Schroer
Alternate:
Joseph Steurnagel

3rd District

ALLEN COUNTY

Delegates:
Joseph M. Oppenheim
Gene E. Wright
Alternate:
Thomas Leech

AUGLAIZE COUNTY

Delegate:
David W. Nielsen
Alternate:
Elizabeth Y. Kuffner

CRAWFORD COUNTY

Delegate:
Johnson H. Chow
Alternate:
Allen V. Auchard

HANCOCK COUNTY

Delegate:
Chester L. Samuelson
Alternate:
Edwin B. Davis

HARDIN COUNTY

Delegate:
Robert B. Elliott
Alternate:
Leonard K. Smith

LOGAN COUNTY

Delegate:
James H. Steiner
Alternate:

MARION COUNTY

Delegate:
Paul E. Lyon
Alternate:
D. Lee Johnson

MERCER COUNTY

Delegate:
James J. Otis
Alternate:
Donald R. Fox

SENECA COUNTY

Delegate:
James A. Murray
Alternate:
J. F. Vela

VAN WERT COUNTY

Delegate:
Jim Evans
Alternate:
Jerry Sell

WYANDOT COUNTY

Delegate:
Herschel A. Rhodes
Alternate:
D. P. Smith

4th District

DEFIANCE COUNTY

Delegate:
Allen Zimmer
Alternate:
Alan Gaspar

FULTON COUNTY

Delegate:
Benjamin H. Reed, Jr.
Alternate:
Vernon L. Cotterman

HENRY COUNTY

Delegate:
Robert J. Blough
Alternate:
Thos. Francis Moriarty

LUCAS COUNTY

Delegates:
John A. Devany
Frank E. Foss
Roland A. Gandy, Jr.
B. Leslie Huffman, Jr.
James A. Jagodzinski
Jerome Kimmelman
Thomas J. O'Grady
Peter A. Overstreet
Richard J. Wiseley
Alternates:
Arturo Castillo
Donnan B. Harding, Jr.
John H. Hasley
Frederic C. Henry
Howard S. Madigan
Antonio B. Paat
S. Theodore Pinsky
Lance A. Talmage
Richard T. Torchia

OTTAWA COUNTY

Delegate:
John F. Bodie
Alternate:
Vincent Wm. Wagner

PAULDING COUNTY

Delegate:
Kirkwood A. Pritchard
Alternate:
Donald K. Snyder

PUTNAM COUNTY

Delegate:
James B. Overmier
Alternate:
John R. Brown

SANDUSKY COUNTY

Delegate:
Willis L. Damschroeder
Alternate:
Samuel R. Lowery

WILLIAMS COUNTY

Delegate:
John E. Moats
Alternate:
Robert W. Dilworth

WOOD COUNTY

Delegate:
Douglas S. Hess
Alternate:
Charles Smith

5th District

ASHTABULA COUNTY

Delegate:
S. E. Gates
Alternate:
A. F. Urankar

CUYAHOGA COUNTY

Delegates:
Carl S. Asseff
Felino V. Barnes
Donavin A. Baumgartner, Jr.
Matthew R. Biscotti

Donald F. Brittenum
Theodore J. Castele
James B. Daley
Daniel A. Deutschman
Richard B. Fratianne
Parrish W. Garver
Ray W. Gifford
Thomas E. Gretter
Edward G. Kilroy
Henry G. Krueger
George P. Leicht
Leroy W. Matthews
Richard J. Nowak
Casimer F. Radkowski
Leonard P. Rome
Franklyn J. Simecek
Peggy-Jeanne St. Clair
Warner W. Tuckerman
Robert J. White
Robert M. Zollinger, Jr.

Alternates:

Isidro J. Amigo
Charles P. Bartley
Norman Bash
Wilma F. Bergfeld
Dean H. Bernacchia
John H. Budd
Benedict J. Colombi
Dale H. Cowan
John D. Desprez
Edwin H. Eigner
John J. Gaughan
Robert C. Grotz
William M. Hegarty
Charles L. Hudson
Edgar B. Jackson, Jr.
Donald W. Junglas
John A. Kmieck
Elroy D. Kursh
James A. MacKay
Lawrence H. Malm
Hermann Menges, Jr.
Valentin F. Mersol
Bienvenido Ortega
Joan C. Palomaki
James L. Phillips
Robert V. Spurney

GEAUGA COUNTY

Delegate:

Oscar A. Brinckmann

Alternate:

Bruce F. Andreas

LAKE COUNTY

Delegates:

John A. Bukovnik
Harry A. Killian

Alternates:

David L. Farrington
Ronald J. Taddeo

6th District

COLUMBIANA COUNTY

Delegate:

William S. Banfield

Alternate:

Leonard S. Pritchard

MAHONING COUNTY

Delegates:

J. James Anderson
Paul J. Mahar, Jr.
John C. Melnick
C. Edward Pichette
William E. Sovik

Alternates:

G. Robert Barton
Anthony T. Deramo
David E. Pichette
Joseph W. Tandatnick
Karl F. Wieneke

STARK COUNTY

Delegates:

Henry H. Clapper
E. Joel Davis
Edward E. Grable
Raymond J. McMahon, Jr.
Reich L. Watterson, Jr.

Alternates:

George Ewing
Richard A. Feezel
Jack G. Hendershot
David M. Montgomery
James A. Niffenegger

TRUMBULL COUNTY

Delegates:

Joseph Sudimack, Jr.
John O. Vlad

Alternates:

Eduardo T. Angnardo
Rodolfo Ballesteros

7th District

BELMONT COUNTY

Delegate:

Joseph Williams

Alternate:

J. P. Antalis

CARROLL COUNTY

Delegate:

Carl A. Lincke

Alternate:

Nan Bissell

COSHOCTON COUNTY

Delegate:

Norman L. Wright

Alternate:

Robert R. Johnson

HARRISON COUNTY

Delegate:

Elias Freeman

Alternate:

John Kuziak

JEFFERSON COUNTY

Delegate:

J. Cottrell

Alternate:

N. Terezis

MONROE COUNTY

Delegate:

Jack M. Matheny II

Alternate:

Donald R. Piatt

TUSCARAWAS COUNTY

Delegate:

Philip T. Doughten

Alternate:

Benjamin J. Wherley

8th District

ATHENS COUNTY

Delegate:

John F. Kroner

Alternate:

Kenneth D. Woods

FAIRFIELD COUNTY

Delegate:

James L. Barrett

Alternate:

James A. Merk

GUERNSEY COUNTY

Delegate:

Robert A. Ringer

Alternate:

William S. Quigley

LICKING COUNTY

Delegate:

John P. Anderson, Jr.

Alternate:

Lawrence Dils

MORGAN COUNTY

Delegate:
Austin A. Coulson
Alternate:
Henry Bachman

MUSKINGUM COUNTY

Delegate:
John W. Ray
Alternate:
Benjamin Gilliotte

NOBLE COUNTY

Delegate:
Edward G. Ditch
Alternate:
Frederick M. Cox

PERRY COUNTY

Delegate:
Ralph Herendeen
Alternate:
S. N. Lord

WASHINGTON COUNTY

Delegate:
Gregory B. Krivchenia
Alternate:
Kenneth E. Bennett

9th District

GALLIA COUNTY

Delegate:
Thomas P. Price, Jr.
Alternate:
Daniel H. Whiteley

HOCKING COUNTY

Delegate:
Direilo Ponserrada
Alternate:
Jan S. Matthews

JACKSON COUNTY

Delegate:
John Wm. Zimmerly
Alternate:
Carl J. Greever

LAWRENCE COUNTY

Delegate:
James B. Zimmerman
Alternate:
John A. Mayer

MEIGS COUNTY

Delegate:
E. S. Villanueva
Alternate:
Joseph J. Davis

PIKE COUNTY

Delegate:

Alternate:

SCIOTO COUNTY

Delegate:
Richard Villarreal
Alternate:
Louis Chaboudy

VINTON COUNTY

Delegate:

Alternate:

10th District

DELAWARE COUNTY

Delegate:
David R. Smith, Jr.
Alternate:
Michael D. Reuter

FAYETTE COUNTY

Delegate:

Alternate:

FRANKLIN COUNTY

Delegates:
Homer A. Anderson
Michael A. Anthony
James E. Barnes
J. Richard Briggs
Walter M. Haynes, Jr.
James E. Matson
Paul S. Metzger
George W. Paulson
H. William Porterfield
Jack E. Tetirick
Alternates:
Ben Arnoff
Ronald B. Berggren
Janet K. Bixel
James W. Kilman
William T. Paul
Alexander Pollack
Warren W. Smith
Louis E. Vassy
Robert L. Wall
Claire V. Wolfe

KNOX COUNTY

Delegate:
Henry T. Lapp
Alternate:
Roger H. Sherman

MADISON COUNTY

Delegate:
Sol Maggied
Alternate:
William T. Bacon

MORROW COUNTY

Delegate:
D. James Hickson
Alternate:
William S. Deffinger

PICKAWAY COUNTY

Delegate:
Ray Carroll
Alternate:
Primo Exconde

ROSS COUNTY

Delegate:
Joseph S. McKell
Alternate:
James Manchester

UNION COUNTY

Delegate:
John B. Ziegler
Alternate:

11th District

ASHLAND COUNTY

Delegate:
H. V. Marley
Alternate:
Jon H. Cooperrider

ERIE COUNTY

Delegate:
James R. Hart
Alternate:
William Birmingham

HOLMES COUNTY

Delegate:
Luther W. High
Alternate:
Maurice E. Mullet

HURON COUNTY

Delegate:
Dennis Ross Irons
Alternate:

LORAIN COUNTY

Delegates:
John N. Bartone
Fred E. Hofman
Robert P. McFarland
Alternates:
Raymundo de la Pena
William H. Miller
Stephen M. Ticich

MEDINA COUNTY

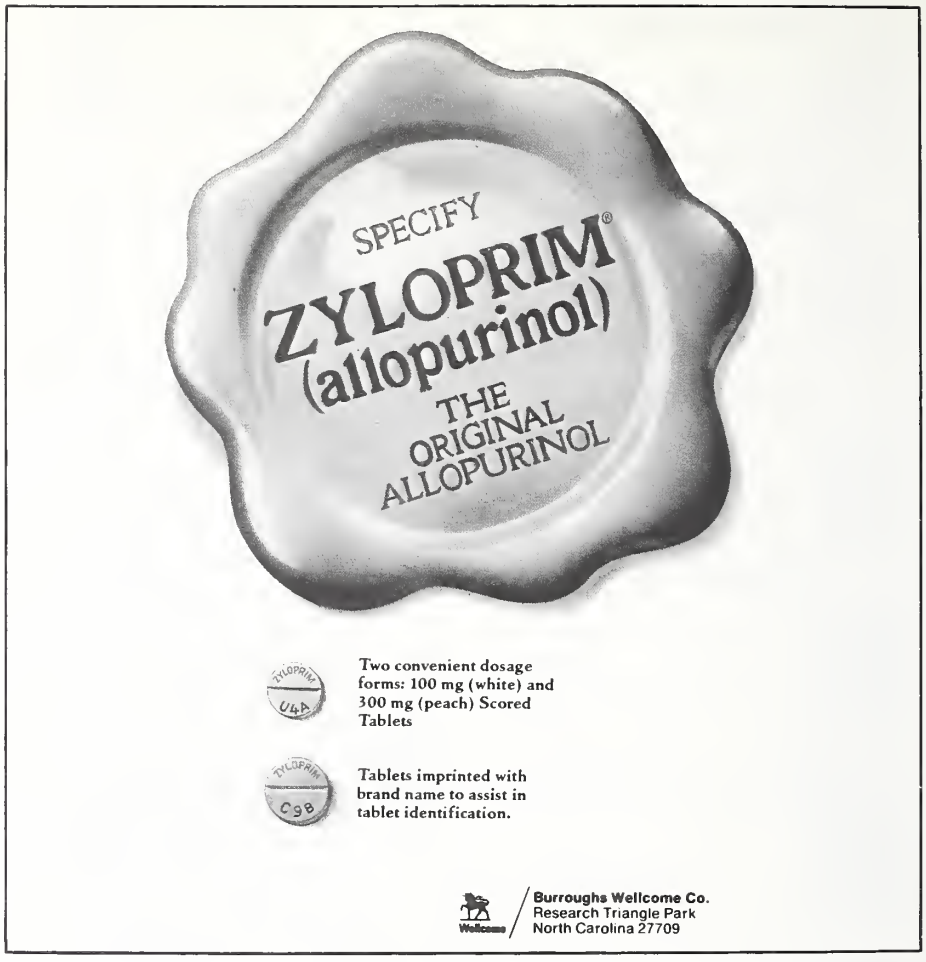
Delegate:
Richard W. Avery
Alternate:
Rolland L. Mansell

RICHLAND COUNTY

Delegates:
James F. Clements
James W. Wiggin
Alternates:
John L. Marquardt
John A. Savoy

WAYNE COUNTY

Delegate:
A. Burney Huff
Alternate:
John M. Robinson



12th District

PORTAGE COUNTY

Delegate:
David Palmstrom
Alternate:
Alan Yoho

SUMMIT COUNTY

Delegates:
Charles A. East
Manley L. Ford
Paul D. Gatewood
Paul W. Kilway, Jr.
Joseph L. Kloss
Frank P. Urso
Francis J. Waickman

Alternates:
Fred Barton
Joseph J. Bastolla
Charles V. Bowen
A. W. Franklin
A. L. Leiby
Robert E. Marsico
E. Gates Morgan
J. Joseph Payton
Michael D. Serene
Fred F. Somma
Jack L. Summers

OSMA Officers

President ..... Robert G. Thomas
President-Elect ... Stewart B. Dunsker
Past President ... Thomas W. Morgan
Secretary-Treasurer ..... David A. Barr

OSMA Councilors

First District ..... John E. Albers
Second
District ..... Herman I. Abromowitz
Third District ..... Alford C. Diller
Fourth District ..... C. Douglass Ford
Fifth District ..... Edward G. Kilroy
Sixth District ..... Joseph P. Yut
Seventh District .... H. Judson Reamy
Eighth District ..... Carl E. Spragg
Ninth District ..... A. Burton Payne
Tenth District ..... D. James Hickson
Eleventh District .... S. Baird Pfahl, Jr.
Twelfth District ... William Dorner, Jr.

Delegates and Alternate Schedule

SUNDAY, MAY 17

3:00 - 7:00 PM
Registration for OSMA House of Delegates
Ballroom Foyer, Stouffer's

4:00 PM
Councilor District Caucus Meetings
(NOTE: Caucus suites will not be assigned prior meeting time — check location at registration desk.)

5:30 PM
Dinner for Delegates, Alternates, OSMA Council and Official Guests
Gold Room, Stouffer's

7:00 PM
Opening Session, OSMA House of Delegates
Grand Ballroom, Stouffer's

BUSINESS AGENDA

Call to Order
Robert G. Thomas, M.D., Elyria
OSMA President

Invocation
Howard A. Simon, Rabbi
K. K. Bene Israel/Rockdale Temple, Cincinnati

Welcome
Robert M. Zollinger, Jr., M.D., M.D., Cleveland
President, Academy of Medicine of Cleveland and Cuyahoga County

Report
Committee on Credentials

Consideration of Minutes of 1980 Annual Meeting
(See July 1980 issue of *The Ohio State Medical Journal*)

Introduction of Member of the AMA Board of Trustees

Introduction of Honored Guests

PICO Report
George N. Bates, M.D., Toledo
Chairman of the Board of Trustees
The Physicians Insurance Co. of Ohio

Report
Mrs. Sarah N. Sato, Willoughby
OSMA Auxiliary President

Presentation of the OSMA 1981 Distinguished Service Award
Charles L. Hudson, M.D., Bratenahl

AMA-ERF Presentations
Philip B. Hardymon, M.D., Columbus
Chairman, Ohio Committee on AMA-ERF

Presentation of Plaques
To past Councilors, retiring AMA Delegates and Alternates and Chairmen of Committees.

Announcement
Robert G. Thomas, M.D., Elyria. Appointments to the Reference Committee on Credentials, President's Address, Resolutions, and Tellers and Judges of Election.

Elections of Committee on Nominations
Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Wednesday, May 20, 3:30 PM, its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Eighth District shall serve as Chairman. The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at the registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

President's Address
Robert G. Thomas, M.D., Elyria

Introduction of Presidents of Other State Societies

Introduction of Resolutions
Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Wednesday afternoon session before any action can be taken.

Miscellaneous Business

WEDNESDAY, MAY 20

2:30 PM
Registration for OSMA House of Delegates
Ballroom Foyer, Stouffer's

3:30 PM
House of Delegates Final Session
Grand Ballroom, Stouffer's

6:00 PM
Dinner for Delegates, Alternates, OSMA Council and Official Guests
Gold Room, Stouffer's

7:00 PM
Continuation of Final Session
Grand Ballroom, Stouffer's

BUSINESS AGENDA

Introduction of Guests

Presentation of Journal Photographic Awards

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of Other Officers

Election of Members of the Council
Members of The Council are elected for two-year terms; terms of those representing the even-numbered districts expire in odd-numbered years. *Second District:* Incumbent, Herman I. Abromowitz, Dayton; *Fourth District:* Incumbent, C. Douglass Ford, Toledo; *Sixth District:* Incumbent, Joseph P. Yut, Canton; *Eighth District:* Incumbent, Carl E. Spragg, New Concord; *Tenth District:* Incumbent, D. James Hickson, Mt. Gilead; *Twelfth District:* Incumbent, William Dorner, Jr., Akron.

Election of Delegates and Alternates to the AMA
Five Delegates and five Alternates to be elected for a two-year term starting January 1, 1982, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1981, their terms expiring December 31, 1981.

Delegates: (listed alphabetically) John E. Albers, Cincinnati; George N. Bates, Toledo; Oscar W. Clarke, Gallipolis; John J. Gaughan, Cleveland; one vacancy.

Alternates:
Theodore J. Castele, Cleveland; William Dorner, Jr., Akron; C. Douglass Ford, Toledo; Edward E. Grable, Canton; Thomas W. Morgan, Gallipolis.

In addition, due to an increase in AMA membership, Ohio is entitled to 10 Delegates and 10 Alternate Delegates. This year, it will be necessary to elect one additional Delegate and one additional Alternate for a term beginning May 20, 1981 and ending December 31, 1982.

All nominees for the offices of AMA Delegates and Alternate Delegates shall run at large. Election of Delegates and Alternates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

**SPECIAL ORDER OF BUSINESS
(after-dinner break)
Installation of 1981-1982 Officers

Reports of Reference Committees
President's Address; Resolutions Committee No. 1; Resolutions Committee No. 2; Resolutions Committee No. 3

Miscellaneous Business

Announcement
Stewart B. Dunsker, M.D., Cincinnati
OSMA President

Unfinished Business

Adjournment



WINDSOR HOSPITAL
A NON-PROFIT CORPORATION
— ESTABLISHED 1898 —
CHAGRIN FALLS, OHIO Phone 247-5300
A hospital for the treatment of Psychiatric Disorders.
High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.
Accredited by Joint Commission on Accreditation of Hospitals. **Booklet available on request.**
FRIEDRICH A. LINGL, M.D. Medical Director
GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus
HERBERT A. SIHLER, JR. President
MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

Accidental hypothermia

While accidental hypothermia can occur in anyone who is exposed to severe cold without enough protection, some older people can develop the problem after exposure to relatively mild cold, reports the National Institute on Aging.

Those elderly most likely to develop accidental hypothermia are chronically ill, the poor who are unable to afford enough heating fuel, and those who do not take the normal steps to keep warm.



Resolution Affecting OSMA Constitution and Bylaws

Editor's Note: Pursuant to the requirements of Article XI, Section 1 of the OSMA Constitution, printed below is a copy of a proposed resolution for consideration by the House of Delegates unanimously adopted by the Council on March 7, 1981.

The Resolution amends the OSMA Constitution and Bylaws to create a Medical Student Business Section and also provides for the selection of representatives of the Medical Student Business Section to the House of Delegates.

Please note that the resolution, if adopted by the House of Delegates, would amend the Constitution to provide that one member of council would be a member from the Medical Student Business Section.

Resolution: 1-81

Introduced by:
The OSMA Council

Subject:
To Amend the OSMA Constitution and Bylaws to Create a Medical Student Business Section and to Provide for the Selection of Representatives of the Medical Student Business Section to the House of Delegates

Referred to:

I. Whereas, OSMA Council believes that revision of the OSMA Consitution and Bylaws to create a medical student business section is appropriate, it recommends for adoption by the House of Delegates the following:

"1. **RESOLVED,** That the OSMA Constitution, Article VII, ("The Council"), shall be amended to provide as follows:
The Council shall consist of one councilor from each council or district, **ONE STUDENT MEMBER FROM THE MEDICAL STUDENT BUSINESS SECTION** and the other elected officers of this Association. The council shall be the executive body of this Association and it shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates.

"2. **RESOLVED,** That the OSMA Bylaws, Chapter 1, ("Membership") Section 2 ("Classification of Membership"), Subsection (i) ("Student Members") shall be amended to provide as follows:
Student Members of this Association shall comprise those students in good standing who are pursuing the diploma of Doctor of Medicine or Doctor of Osteopathy in an approved medical or osteopathic college or institution in the State of Ohio and are approved for the student membership by the Council. **STUDENT MEMBERS SHALL COMPRISE THE MEDICAL GROUP KNOWN AS THE MEDICAL STUDENT BUSINESS SECTION. SAID SECTION SHALL BE GOVERNED BY AND OPERATE UNDER SEPARATE BYLAWS APPROVED BY THE COUNCIL. STUDENT MEMBERS IN GOOD STANDING OF THIS ASSOCIATION SHALL HAVE THE RIGHT TO VOTE AND HOLD OFFICE.**

"3. **RESOLVED,** That the OSMA Bylaws, Chapter 7, ("The Council") Section 4, ("Individual Duties of Councilors") shall be amended to provide as follows:
Each Councilor shall be the organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purposes of inquiring into the condition of the profession and of each component society in his district and of keeping in touch with the activities of each of such societies. In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics.
THE DUTIES OF THE COUNCILOR FROM THE MEDICAL STUDENT BUSINESS SECTION SHALL BE SET FORTH IN THE BYLAWS OF SAID SECTION."

II. Whereas, The Constitution and Bylaws of the OSMA have been amended to create a Medical Student Business Section; therefore be it
RESOLVED, That pursuant to the OSMA Constitution, Article IV, ("House of Delegates") Subsection (3), the Medical Student Business Section shall have six representatives to the House of Delegates commencing with the Annual Meeting in 1982, said delegates to be selected in accordance with the Bylaws of the Medical Student Business Section to be approved by Council.

County Society Officers, Executive Directors and Meeting Dates

1st District

Councilor: *John E. Albers, M.D.*, 2350 Auburn Ave., Cincinnati 45219.

ADAMS: Gary Greenlee, M.D., President, 33 E. Second Street, Manchester 45144; David E. Pixley, M.D., Secretary-Treasurer, 154 E. Elliott Ave., Peebles 45660. Second Tuesday.

BROWN: Carl Gandola, M.D., President, Ripley Family Health Center, Ripley 45167; Robert S. Benintendi, M.D., Secretary-Treasurer, Route 1, Box N, S. Main St., Georgetown 45121. First or Second Sunday.

* **BUTLER:** Russell L. Malcolm, Jr., M.D., President, Middletown Hospital Clinical Lab, 105 McKnight Dr., Middletown 45042; John L. Ritan, M.D., Secretary-Treasurer, Middletown Hospital, Middletown 45042; Mrs. Joan Williams, Executive Secretary, 111 Buckeye St., P.O. Box 3216, Hamilton 45013, 513/893-1410. Fourth Wednesday, October - May except December.

CLERMONT: Jimmie Barnes, M.D., President, 7168 Royalgreen Dr., Cincinnati 45244; William Blake Selnick, D.O., Secretary-Treasurer, Second and E. Loveland Aves., Loveland 45140. Second Tuesday.

CLINTON: James E. Rose, M.D., President, 287 Webb Road, Wilmington 45177; Thomas J. Willke, M.D., Secretary-Treasurer, 891 W. Locust St., Wilmington 45177. Fourth Tuesday.

* **HAMILTON:** Donald I. Radin, M.D., President, 629 Oak St., Cincinnati 45206; Walter Wildman, M.D., Secretary, 2139 Auburn Ave., Cincinnati 45219; William J. Galligan, Executive Director, 320 Broadway, Cincinnati 45202, 513/421-7010. Second Tuesday.

HIGHLAND: Barbara Lustgarten, M.D., President, 1440 N. High St., Hillsboro 45133; Glenn B. Doan, M.D., Secretary-Treasurer, 528 South St., Greenfield 45123.

WARREN: Gilbert K. Ohlhauser, M.D., President, 309 Reading Rd., Mason 45040; Walter Meyer, M.D., Secretary, 1004 Oregonia Rd., Lebanon 45036. Second Tuesday.

2nd District

Councilor: *Herman I. Abromowitz, M.D.*, 226 Troy St., Dayton 45404.

CHAMPAIGN: Barry Paxton, M.D., President, 900 Scioto St., Urbana 43078; James B. Hall, M.D., Secretary-Treasurer, 900 Scioto St., Urbana 43078. Second Wednesday.

CLARK: James Gianakopoulos, M.D., President, 34 W. High St., 2nd Fl., Springfield 45502; David Lawrence, M.D., Secretary, 402 N. Broadmoor Blvd., Springfield 45504; Colleen Buscemi, Executive Secretary, 34 W. High St., Room 710, Springfield 45502, 513/324-8618. Third Monday.

DARKE: Samuel M. Brubaker, M.D., President, 307 N. Main St., Arcanum 45304; Jesse L. Heise, M.D., Secretary, Arcanum Medical Center, Arcanum 45304. Third Tuesday.

GREENE: Kazem Khoii, M.D., President, 140 Rogers St., Xenia 45385; Isagani Hernandez, M.D., Secretary-Treasurer, 2365 Dayton-Xenia Rd., Beavercreek 45385; Mrs. Virginia Jones, Executive Secretary, 761 Buckskin Trail, Xenia 45385, 513/376-3783. Third Thursday.

* **MIAMI:** Ramen Das, M.D., President, Piqua Memorial Hospital, Piqua 45356; Peter E. Nims, M.D., Secretary, 27 Robinhood Lane, Ste. 2, Troy 45373. First Tuesday.

MONTGOMERY: Walter W. Keyes, M.D., President, 3025 Big Hill Rd., Dayton 45419; Siavosh Bozorgi, M.D., Secretary, 1790 Miami Valley Tower, Dayton 45402; Richard G. Tapia, Executive Director, 40 S. Perry St., Ste. 100, Dayton 45402, 513/223-1431. Second Thursday except July and August.

PREBLE: John D. Darrow, M.D., President and Secretary, 228 N. Barrow St., Eaton 45320.

SHELBY: George J. Schroer, M.D., President, 1731 Letitia Dr., Sidney 45365; Jerome Mestemaker, M.D., Secretary-Treasurer, 322 Second Ave., Sidney 45365. Second Tuesday.

3rd District

Councilor: *Alford C. Diller, M.D.*, Medical Arts Bldg., 140 Fox Rd., Van Wert 45891.

* **ALLEN:** John D. Albertson, M.D., President, 1893 Idlewild Dr., Lima 45805; Roger L. Terry, M.D., Secretary-Treasurer, Orthopaedic Surgeons of Lima, 1220 E. Elm St., Ste. 110, Lima 45805; Will Wolf, Executive Secretary, Box 1647, Lima 45802, 419/228-3335. Third Tuesday, September - May.

AUGLAIZE: James R. Romaker, M.D., President, 114 W. Main St., Lima 45806; Thomas C. Dozier, D.O., Secretary-Treasurer, 112 S. Court St., St. Marys 45885. First Thursday, January, March, May, September and November.

CRAWFORD: Lawrence A. Pabst, M.D., President, 955 Bucyrus Rd., Galion 44833; Angelito V. Belardo, M.D., Secretary-Treasurer, Galion Community Hospital, Galion 44833.

HANCOCK: Alan T. Tong, M.D., President, 1818 Chapel Dr., No. C., Findlay 45840; William B. Elderbrock,

M.D., Secretary, 1920 S. Main St., Findlay 45840. Third Tuesday.

HARDIN: Jose G. Guzman, M.D., President, 777 Maydoll Dr., Kenton 43326; Jose Castrillo, M.D., Secretary-Treasurer, 110 N. Cherry St., Kenton 43326. Second Tuesday.

LOGAN: Charles L. Barrett, M.D., President, 119 S. Madriver St., Bellefontaine 43311; Thomas C. Franklin, M.D., Secretary-Treasurer, Oakhill Medical Associates, Route 2, West Liberty 43357.

* **MARION:** Edwin G. Davy, M.D., President, Marion General Hospital, McKinley Park Dr., Marion 43302; Vernon Nichols, M.D., Secretary-Treasurer, 318 E. Center St., Marion 43302. First Tuesday except June, July and August.

MERCER: Donald R. Rox, M.D., President, 724 E. Wayne St., Celina 45822; George H. McIlroy, M.D., Secretary-Treasurer, 123 E. Fayette St., Celina 45822. Third Thursday except June, July and August.

SENECA: S.E. Erulkar, M.D., President, c/o Seneca County Medical Society, 423 S. Main St., Fostoria 44830; Pramuan Thirasilpa, M.D., Secretary-Treasurer, c/o Seneca County Medical Society, 423 S. Main St., Fostoria 44830. Third Tuesday except July, August and December.

VAN WERT: Terrence L. Johnson, M.D., President, Medical Arts Bldg., 140 Fox Rd., Van Wert 45891; Robert C. Adams, M.D., Secretary-Treasurer, Medical Arts Bldg., 140 Fox Rd., Van Wert 45891. Third Tuesday.

WYANDOT: Herschel A. Rhodes, M.D., President, 777 N. Sandusky Ave., Upper Sandusky 43351; Konstantin K. Solacoff, Secretary-Treasurer, 777 N. Sandusky Ave., Upper Sandusky 43351. Second Tuesday.

4th District

Councilor: *C. Douglass Ford, M.D.*, 2361 W. Bancroft St., Toledo 43607.

DEFIANCE: Benedict B. Lenhart, M.D., President, 1075 E. Second St., Defiance 43512; Jack A. Kane, M.D., Secretary-Treasurer, P.O. Box 70, Defiance 43512. Second Tuesday.

FULTON: Benjamin H. Reed, Jr., M.D., President, 730 Burr Rd., Wauseon 43567; Estela T. Miquiabas, M.D., Secretary-Treasurer, 705 S. Shoop Ave., Wauseon 43567. Second Tuesday, quarterly.

HENRY: Robert J. Blough, M.D., President, 141 N. Keyser Ave., Deshler 43516; Raymond J. Manahan, M.D., Secretary-Treasurer, 1325 Woodlawn Ave., Napoleon 43545. First Tuesday.

LUCAS: Frank E. Foss, M.D., President, 2213 Cherry St., Toledo 43608; James A. Jagodzinski, M.D., Secretary, 3969 Woodhurst, Toledo 43614; Lee F. Wealton, Executive Director, 4428 Secor Rd., Toledo 43623, 419/473-3200. Fourth Tuesday.

OTTAWA: V. William Wagner, M.D., President, 105 Madison St., Port Clinton 43452; Robert S. Reeves, M.D., Secretary-Treasurer, 504 E. Water St., Oak Harbor 43449. Second Thursday, October - June.

PAULDING: William Max Miller, M.D., President, 602 Emerald Ave., Paulding 45879; Edith Pritchard, M.D., Secretary-Treasurer, 742 Miller Parkway Dr., Paulding 45879. Third Monday.

PUTNAM: Oliver N. Lugibihl, M.D., President, Box 235, Pandora 45877; Charles Kidd, M.D., Secretary-Treasurer, Box 256, Kalida 45853. First Tuesday.

SANDUSKY: P.I. Mathew, M.D., President, 1922 Glen Springs Dr., Fremont 43420; John L. Zimmerman, M.D., Secretary-Treasurer, Memorial Hospital, Fremont 43420; Mrs. Patsy J. Reed, Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420, 419/332-7321. Quarterly.

WILLIAMS: Clarence Bell, M.D., President, 904 Snyder Ave., Montpelier 43543; Richard L. Hess, M.D., Secretary-Treasurer, 442 W. High St., Bryan 43506; Rebecca Cape, Executive Secretary, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506, 419/636-4517. Third Tuesday, January, March, May, September and November.

WOOD: Marjorie E. Conrad, M.D., President, 15819 Bowling Green Rd., W., Bowling Green 43402; Richard D. Barker, M.D., Secretary-Treasurer, 6960 W. Wooster, LL No. 101, Bowling Green 43402. Third Thursday.

5th District

Councilor: *Edward G. Kilroy, M.D.*, 20800 Westgate Ct., Cleveland 44126.

ASHTABULA: Hector Abueg, M.D., President, 233 Liberty, Conneaut 44030; Albert Kaltenthaler, M.D., Secretary-Treasurer, 2420 Lake Ave., Ashtabula 44004; Miss Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, 216/998-3111. Second Tuesday, February, April, September, November and December.

* **CUYAHOGA:** Richard J. Nowak, M.D., President, 20620 N. Park Blvd., Cleveland 44118; Franklyn J. Simecek, M.D., Secretary-Treasurer, St. Alexis Medical Arts Center, 5109 Broadway No. 202, Cleveland 44127; Robert A. Lang, Ph.D., 11001 Cedar Road, Cleveland 44106, 216/229-2200. Second Tuesday.

GEAUGA: Vichai Duangjak, M.D., President, 12475 Hospital Dr., Chardon 44024; Arturo Dimaculangan, M.D., Secretary-Treasurer, 13346 Ravenna Rd., Chardon 44024; Mrs. Margaret Pace, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, 216/286-6131. Second Thursday.

LAKE: Elmer V. Demeter, M.D., President, 89 E. High St. No. 7, Painesville 44077; Ronald Posner, M.D., Secretary-Treasurer, 10051 Candlestick Lane, Painesville 44077; Mrs. Jan Vargo, Executive Secretary, Lake County Memorial Hospital, 71 E. High St., Painesville 44077. 216/352-4481. February, May, September and November.

6th District

Councilor: *Joseph P. Yut, M.D.*, 201 Dueber Ave., SW, Canton 44706.

COLUMBIANA: Marcio D. Soares, M.D., President, 238 Front St., Leetonia 44431; Orlando Castro, Secretary-Treasurer, 129 W. Fourth St., East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 163 Park Ave., Salem 44460, 216/337-8859. Third Tuesday except June, July, August and December.

MAHONING: D. J. Dallis, M.D., President, 550 Parmalee Ave., Youngstown 44510; H. S. Wang, M.D., Secretary, 10 Dutton Dr., Youngstown 44502; Robert B. Blake, Executive Director, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 44504, 216/747- 4956. Third Tuesday, January, March, June, September, November and December.

STARK: Guillermo R. Sicard, M.D., President, 515 Third St., NW, Canton 44703; James Burkholder, M.D., Secretary-Treasurer, 4150 Belden Village St., NW, No. 400, Canton 44718; Nancy Adams, Executive Secretary, 4150 Belden Village St., NW, Canton 44718, 216/492-3333. Second Tuesday.

TRUMBULL: John Biggins, M.D., President, 8887 Echo Lake Dr., NE, Warren 44484; Engelbert Hecker, M.D., Secretary-Treasurer, 9070 Echo Lake Dr., Warren 44484; Mrs. Delores B. Bevan, Executive Secretary, 280 N. Park Ave., Warren 44481, 216/394-4556. Third Wednesday except June, July and August.

7th District

Councilor: *H. Judson Reamy, M.D.*, 931 Fourth St. NW, New Philadelphia 44663.

BELMONT: Joseph L. Williams, M.D., President, Bellaire Clinic, Bellaire 43906; Nermin D. Lavapies, M.D., Secretary-Treasurer, Martins Ferry Hospital, Martins Ferry 43934. Third Thursday, February - April, September - November.

CARROLL: Nan M. Bissell, M.D., President, 450 S. Lisbon St., Box 338, Carrollton 44615; Charles Steiner II, M.D., Secretary-Treasurer, 207 Second St. SW, Carrollton 44615. Third Tuesday.

COSHOCTON: Francisco F. Sison, M.D., President, 125 N. Seventh St., Coshocton 43812; Myron Saturski, M.D., Secretary-Treasurer, P.O. Box 258, Newcomerstown 43832. Second Tuesday.

HARRISON: Ajit S. Modi, M.D., President, R.D. No. 1, Cadiz 43907; Prasad R. Siripurapu, M.D., Secretary-Treasurer, Main Street, Box 323, Jewett 43986. Second Tuesday.

JEFFERSON: James W. Valuska, M.D., President, 2990 Johnson Rd., Steubenville 43952; William E. Johns, M.D., Secretary-Treasurer, 203 McLister Ave., Mingo Junction 43938. First Tuesday.

MONROE: Donald R. Piatt, M.D., President, 154 S. Main St., Woodsfield 43793; Jack M. Matheny II, M.D., Secretary-Treasurer, Monroe County Clinic, Old Airport Road, Route 3, Woodsfield 43793. First Wednesday, every fourth month.

TUSCARAWAS: Robert Ley III, M.D., President, 1716 Cross St., Dover 44622; Rachappa Nalawadi, M.D., Secretary, 146 E. Main St., Gnadenhutten 44629. Second Wednesday.

8th District

Councilor: *Carl E. Spragg, M.D.*, 71 W. Main St., New Concord 43762.

ATHENS: Mark Rothstein, M.D., President, 530 W. Union St., Athens 45701; John Cunningham, M.D., Secretary-Treasurer, 444 W. Union St., Athens 45701. Second Tuesday, March, June, September, December.

FAIRFIELD: Robert E. Whetstone, M.D., President, Box 338, Pleasantville 43148; David H. Sheidler, M.D., Secretary-Treasurer, 1500 E. Main, Lancaster 43130. Second Tuesday.

GUERNSEY: Emmanuel Noche, M.D., President, 1432 N. Clark St., Cambridge 43725; A. R. Srikantiah, M.D., Secretary-Treasurer, 9884 Cadiz Rd., Cambridge 43725. First Tuesday, except July and August.

LICKING: Nick P. Trifelos, M.D., President, 36 McMillen Dr., Newark 43055; Charles Marty, M.D., Secretary-Treasurer, 1272 W. Main, Bldg. No. 2, Newark 43055; Mrs. Lindsay Freytag, Executive Secretary, 1320 W. Main St., Newark 43055, 614/344-0331, Ext. 394. Fourth Tuesday, except June, July, August and September.

MORGAN: Asia H. Whitacre, M.D., President, R. D. No. 1, Chesterhill 43728; Henry Bachman, M.D., Secretary-Treasurer, 426 E. Union Ave., McConnelsville 43756.

MUSKINGUM: Sterling W. Obenour, Jr., M.D., President, 1038 Maple Ave., Zanesville 43701; David L. Klein, M.D., Secretary-Treasurer, 2447 Maple Ave., Zanesville 43701. First Tuesday, except June, July and August.

NOBLE: Frederick M. Cox, M.D., President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, M.D., Secretary-Treasurer, P.O. Box 239, Caldwell 43724. First Tuesday.

PERRY: Charles E. Bope, M.D., President, W. Main St., Somerset 43783; Michael P. Clouse, M.D., Secretary-Treasurer, Clouse Clinic, W. Main St., Somerset 43783.

WASHINGTON: Curtis L. Dehmlow, M.D., President, 504 Second St., Marietta 45750; Richard Hershey, M.D., Secretary-Treasurer, Marietta Memorial Hospital, Marietta 45750. Second Wednesday.

9th District

Councilor: *A. Burton Payne, M.D.*, 411 Center St., Ironton 45638.

GALLIA: James C. Maher III, M.D., President, Holzer Clinic, Ltd., P.O. 344, Gallipolis 45631; James R. Magnussen, M.D., Secretary-Treasurer, Holzer Clinic, Ltd., P.O. Box 344, Gallipolis 45631. Quarterly.

HOCKING: George T. Ralph, M.D., President, P.O. Box 987, Logan 43138; John E. Rauch, D.O., Secretary-Treasurer, 207 Falls, Logan 43138.

JACKSON: John W. Zimmerly, M.D., President, Rt. 1, Box 299-A, Jackson 45640; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640.

LAWRENCE: Rodolfo J. Canos, M.D., President, P.O. Box 533, Ironton 45638; David A. Pack, M.D., Secretary-Treasurer, 2412 S. Sixth St., Ironton 45638. Third Thursday, bimonthly.

MEIGS: Selim Blazewicz, M.D., President, P.O. Box 511, Pomeroy 45769; Wilma Mansfield, M.D., Secretary-Treasurer, P.O. Box 351, Pomeroy 45769.

PIKE: Kenneth A. Wilkinson, M.D., President, Hilltop Medical Center, Rt. No. 2, Waverly 45690; Darrell K. Wells, M.D., Secretary-Treasurer, 216 Emmitt Ave., Waverly 45690.

SCIOTO: David E. Livingston, M.D., President, 1723 27th St., Portsmouth 45662; John K. Borders, M.D., Secretary-Treasurer, 1725 27th St., Portsmouth 45662; Lowell Thompson, Executive Secretary, P.O. Box 1348, Portsmouth 45662, 614/354-7581. Second Tuesday.

VINTON: No active society.

10th District

Councilor: *D. James Hickson, M.D., Box 208, Mt. Gilead 43338.*

DELAWARE: Victor E. Badertscher, M.D., President, 43 Northwood Dr., Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, 141 S. Main St., Prospect 43342. Third Tuesday, March, May, September, December.

FAYETTE: Robert U. Anderson, M.D., President, 114 N. North, Washington C.H. 43160; Marvin H. Roszmann, M.D., Secretary-Treasurer, 1005 E. Temple, Washington C.H. 43160. Second Friday.

FRANKLIN: George W. Paulson, M.D., President, 931 Chatham Lane, Columbus 43221; Frederik S. Barends, M.D., Secretary-Treasurer, 3360 E. Livingston Ave., Columbus 43227; James S. Imboden, Executive Director, 600 S. High St., Columbus 43215, 614/224-6116. February, August, September, October.

* **KNOX:** James H. Risko, M.D., President, 307 Vernedale Dr., Mt. Vernon 43050; Herbert M. Sinton, M.D., Secretary-Treasurer, 307 Vernedale Dr., Mt. Vernon 43050. First Wednesday.

MADISON: J. William Hurt, M.D., President, 35 S. Twin St., West Jefferson 43162; Sol Maggied, M.D., Secretary-Treasurer, 15 E. Pearl, West Jefferson 43162. Second Wednesday, quarterly.

MORROW: Joseph P. Ingmire, M.D., President, 28 W. High St., Mt. Gilead 43338; D. James Hickson, M.D., Secretary, Box 208, Mt. Gilead 43338. First Tuesday.

PICKAWAY: Louise O. Warner, M.D., President, 528 S. 17th St., Columbus 43205; Michael E. Geron, M.D., Secretary-Treasurer, Circleville Medical Associates, 111 Island Rd., Circleville 43113. Second Tuesday, except July and August.

ROSS: David E. Smith, M.D., President, 394 Chestnut St., Chillicothe 45601; David McKell, M.D., Secretary-Treasurer, 60 Central Center, Chillicothe 45601. Second Tuesday.

UNION: John B. Ziegler, M.D., President, 18522 Raymond Rd., Marysville 43040; May B. Zaugg, M.D., Secretary-Treasurer, 509 Hickory Dr., Marysville 43040. First Tuesday, February, April, October, December.

11th District

Councilor: *S. Baird Pfahl, Jr., M.D.,* 521 W. Perkins Ave., Sandusky 44870.

ASHLAND: Lorand C. Reich, M.D., President, 127 N. Water St., Loudonville 44842; Chung K. Kang, M.D., Secretary-Treasurer, 408 Center St., P.O. Box 632, Ashland 44805. First Tuesday.

ERIE: Charles J. Everett, M.D., President, 3207 Campbell St., Sandusky 44870; Douglas C. Rist, M.D., Secretary, 2528 Columbus Ave., Sandusky 44870; Mrs. Barbara Wolfert, Executive Secretary, 2710 Scheid Rd., Huron 44839, 419/433-3097. Second Tuesday, except July and August.

HOLMES: Lawrence S. Eby, M.D., President, 420 Wooster Rd., Millersburg 44654; Kim Boyd, M.D., Secretary-Treasurer, Box 143, Walnut Creek 44687. Second Monday.

HURON: Farid H. Said, M.D., President, 21 W. Main St., Wakeman 44889; Gordon Harper, Secretary-Treasurer, 813 Northwest St., Bellevue 48811. Second Wednesday, February, April, June, October, December.

LORAIN: Ward Young, M.D., President, 1511 Lincoln Blvd., Lorain 44055; Hemendra Mehta, M.D., Secretary-Treasurer, 905 E. Broad St., Elyria 44035; Mrs. Alice Waite, Executive Secretary, 1480 N. Ridge Rd. East, Elyria 44035, 216/324-3093. Second Tuesday.

MEDINA: Keshiau Chen, M.D., President, 970 E. Washington St., Medina 44256; Thomas G. Ebner, M.D., Secretary-Treasurer, 3880 E. Smith Road, Medina 44256; John E. Gerding, Executive Secretary, 3377 Forest Hills Dr., Medina 44256, 216/725-5331. Third Thursday.

RICHLAND: Joel E. Kaye, M.D., President, 551 Forest Hill Rd., Mansfield 44907; James D. Curry, M.D., Secretary-Treasurer, 335 Glessner Ave., Mansfield 44903; Mrs. M.K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903, 419/522-3411. Third Thursday, except June, July and August.

WAYNE: Thomas C. Richard, M.D., President, 1740 Cleveland Rd., Wooster 44691; Owen W. Logee, M.D., Secretary-Treasurer, 1874 Cleveland Rd., Wooster 44691. Second Wednesday, every second month.

12th District

Councilor: *William Dorner, Jr., M.D.,* 750 W. Market St., Akron 44303.

PORTAGE: John F. Fulton, M.D., President, c/o Portage County Medical Society, 6693 N. Chestnut St., Ravenna 44266; A. N. Can, M.D., Secretary-Treasurer, c/o Portage County Medical Society, 6693 N. Chestnut St., Ravenna 44266. Second Tuesday.

SUMMIT: Aris W. Franklin, M.D., President, 20 S. Broadway St., Akron 44308; E. Gates Morgan, M.D., Secretary, 3461 S. Smith Rd., Akron 44313; S. H. Mountcastle, Managing Director, 430 Grant St., Akron 44313, 216/434-1921. First Tuesday, January, March, May, July, September, November.

** Editor's Note: These counties change officers between May and September.*

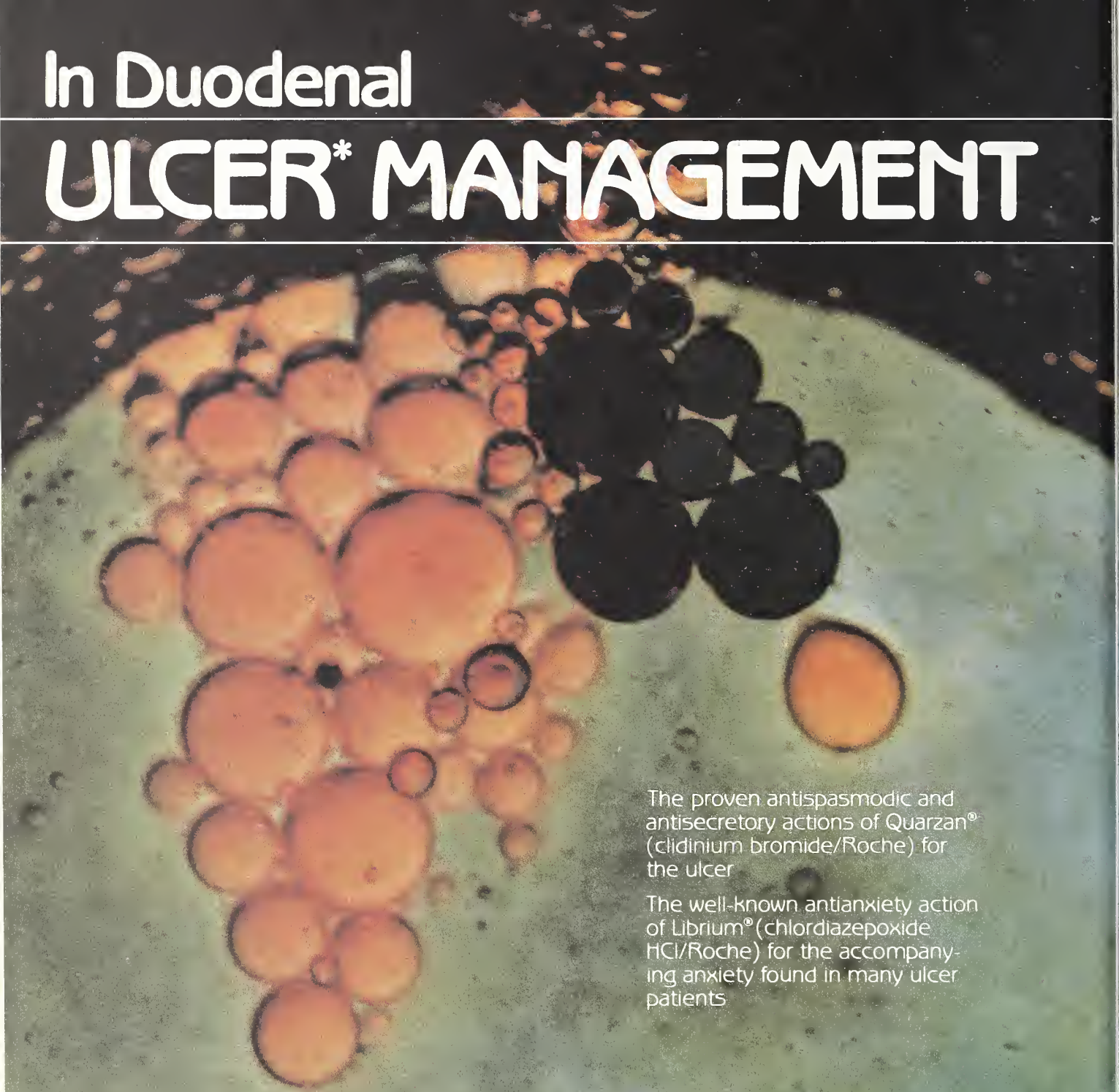
Toxic shock declining

Cases of toxic shock syndrome are decreasing rapidly, but the Center for Disease Control still is seeking concrete reasons for the drop.

Of more than 940 cases reported, there were 119 in August, 106 in September (Rely brand tampons were taken off the market in late September), 58 in October, 42 in November, and 39 in December.

There is a close correlation between the withdrawal of Rely tampons from the market and the decreasing number of cases. However, CDC has not pinpointed a reason why Rely might trigger the disease, said Bruce Dan, M.D., a member of CDC's Toxic Shock Syndrome Task Force based in Atlanta.
— From the AMA News

In Duodenal ULCER* MANAGEMENT



The proven antispasmodic and antisecretory actions of Quarzan® (clidinium bromide/Roche) for the ulcer

The well-known antianxiety action of Librium®(chlordiazepoxide HCl/Roche) for the accompanying anxiety found in many ulcer patients

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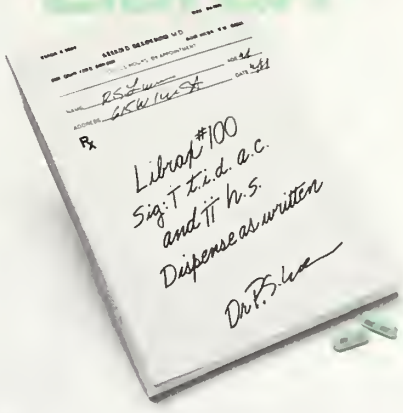
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

Antianxiety/Antisecretory/Antispasmodic

*Librax has been evaluated as possibly effective for this indication. Please see brief summary of prescribing information on facing page.

Photograph of simulated gastric hypersecretion.

Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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BOOK SHELF

Manual for Eye Examination and Diagnosis. *By Mark W. Leitman, M.D., Samuel Gartner, M.D., and Paul Henkind, M.D., Ph.D. Medical Economics Books, $8.95.*

This second edition of the **Manual for Eye Examination and Diagnosis** has been revised, expanded, and enlarged to include new text material, as well as reviews of the symptoms, causes, and therapy for the most common ocular diseases.

Because the tests and techniques included in the manual are organized and presented in the proper sequence for conducting an eye examination, the book is valuable as a working guide for the practicing physician, and as a test and reference source for medical students.

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The Bayer truth

A Federal Trade Commission judge has ruled that Sterling Drugs, Inc., has improperly advertised Bayer Aspirin as being more effective than other aspirin.

"The manufacturer has used a series of misleading claims in its advertising for Bayer Aspirin, Bayer Children's Aspirin, Vanquish, Cope, and Midol," said Administrative Law Judge Montgomery K. Hyun in his ruling, but he rejected requests by FTC lawyers for an order which would have required Sterling to buy new ads, correcting the old ones.

Future ads, he ordered, will have to say when aspirin is an ingredient and will have to stop referring to commonly known ingredients such as aspirin and caffeine by unfamiliar names.

Sterling said it still believes its advertising "appropriately and accurately reflected the scientific data," and said it would appeal Judge Hyun's ruling to the full five-member FTC.

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Victor Whitacre, M.D., displays his prowess on the slopes.

Now, here's . . .

A real cliff hanger

By Gina C. Cummins

"A man climbs
because he needs to climb,
because that's the way he is made."
James Ramsey Ullman

If your idea of a challenging climb is up the basement steps, then you'll have trouble keeping pace with mountain climbing buff Victor Whitacre, M.D.

As with all mountain climbers, Dr. Whitacre has been known to climb a mountain just because it is there, but for him, there is more: the exercise; a welcome and often much-needed escape from his busy family practice in Beverly, Ohio; and the challenge.

After 22 years of mountain climbing, the challenge is still there — but not as often. "In my younger days, I used to go climbing 50 to 100 times a year. Now I'm down to 15 or 20," he grins.

Dr. Whitacre's interest in climbing was kindled nearly 40 years ago during a visit to the Grand Teton mountain range in Wyoming. As a young man of 17, he stood mesmerized while his father and friends scaled the mountainside. Ten years later, his fascination drew him back, "but everyone told me that I was just too big and fat to climb." Determined to prove them wrong, Dr. Whitacre returned eight years later to make his first climb. "I've been an avid enthusiast ever since."

Since then, Dr. Whitacre's hobby has taken him gallivanting all over the country — including the Shawangunk Mountains north of New York City, the Selkirks in British Columbia, and the Seneca rocks in West Virginia.

Although he climbs year round, Dr. Whitacre prefers cool, crisp weather. "The expulsion of calories is so great when mountain climbing that you'll suffer from heat exhaustion if the weather is too hot."

He usually climbs with one or two friends but has gone with crowds of 25. "Never climb alone," advises Dr. Whitacre. "Always climb with one other person for safety's sake." And if you're a beginner, "go with an experienced climber the first couple of times out."

Is his pet hobby as perilous as it may seem? "Not the way I do it. We've run into more danger and trouble on the highways dodging cars than on the mountains." That doesn't mean to say that mountain climbing is without its hazards. "Not being able to judge your ability in relation to the toughness of the climb is perhaps the most dangerous aspect of the sport," he warns, adding that good physical condition is a must. "If you aren't in top shape, accidents happen more readily." Other hazards include equipment failure and the possibility of something falling on you from above. "While climbing, you should always wear a hard hat and make sure your equipment is in satisfactory condition beforehand," he says, noting that climbers should always check for

favorable weather conditions, and always let someone know where they are headed.

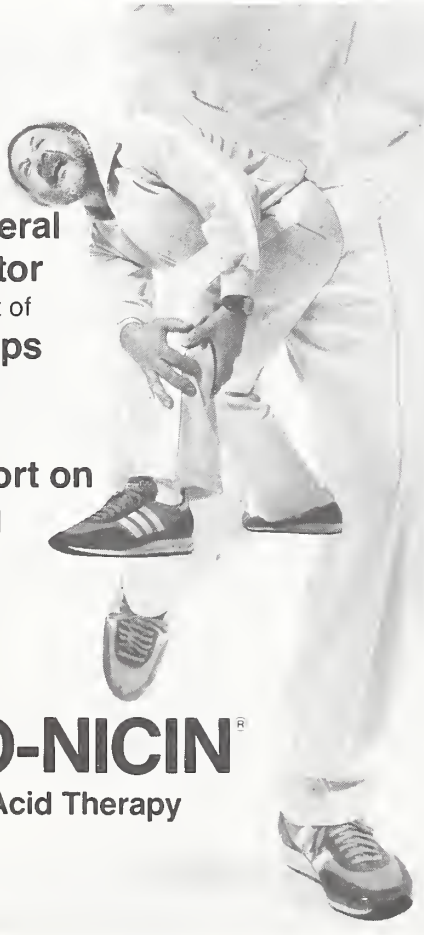
In spite of precautions, accidents do occur. "A friend was taking movies of me while I was descending a mountain. I was repelling, which is the term used as you descend and slide down a rope while trying to control friction. About 20 feet from the bottom my rope broke and down I went. Fortunately, I was wearing heavy clothing which cushioned me as I rolled over and over." The fall was recorded on film and provides a first-hand account of one of the dangers which face mountain climbers.

Is mountain climbing for everyone? "If they can chin themselves once, I can get them up Seneca rocks," boasts Dr. Whitacre. And he has reason to boast. He has taught over 1,000 people how to mountain climb — an impressive record, considering that most of his students have approached him from word-of- mouth "advertising." His love of mountains plus years of experience prompted him to share his knowledge by teaching a course at a local high school on the leadership qualities needed in mountain climbing. But what he can't teach in the classroom, he teaches on location — at the foot of a steep, no-turning-back-now mountain. Dr. Whitacre claims that on-the-spot training is the best and only way to really learn the sport. He stresses *safety* as the most important part of the learning process. "I go with them to the mountain and tell them that if they're 30 feet up and fall, they can end up in a box. I see so many gung-ho seventh and eighth graders who can out-climb me, but hesitate when they are asked to lead a climb because they lack experience and knowledge — that's what I strive to teach."

Sharing what he knows with other plucky kindred spirits has kept Dr. Whitacre's enthusiasm fired — "The best part of all this is showing others who are interested or afraid to try, that they really can do it."



Dr. Whitacre . . . at the top



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Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

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Ascorbic Acid .....150 mg.
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Riboflavin (B-2) .....2 mg.
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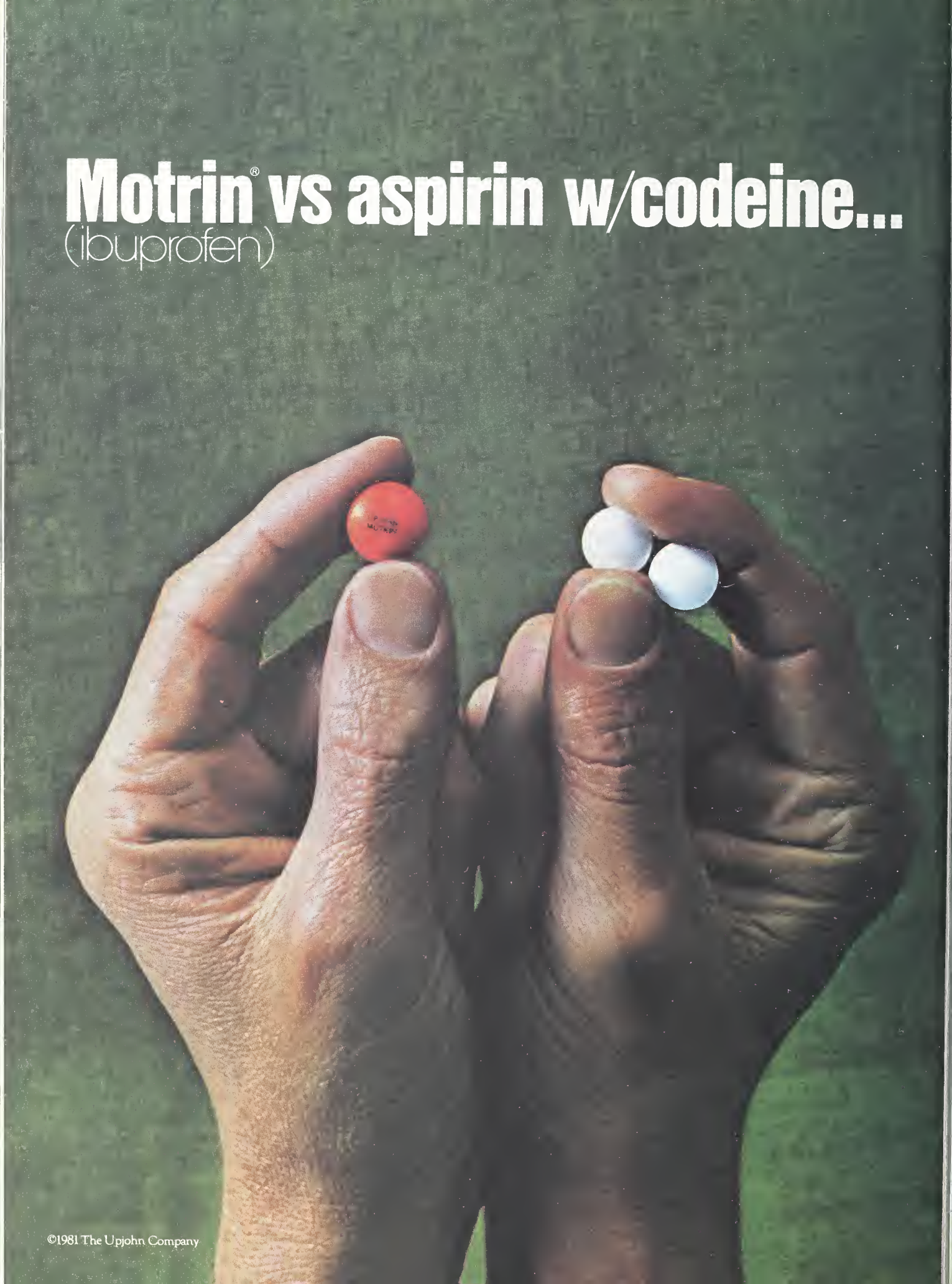
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Motrin® vs aspirin w/codeine...
(ibuprofen)

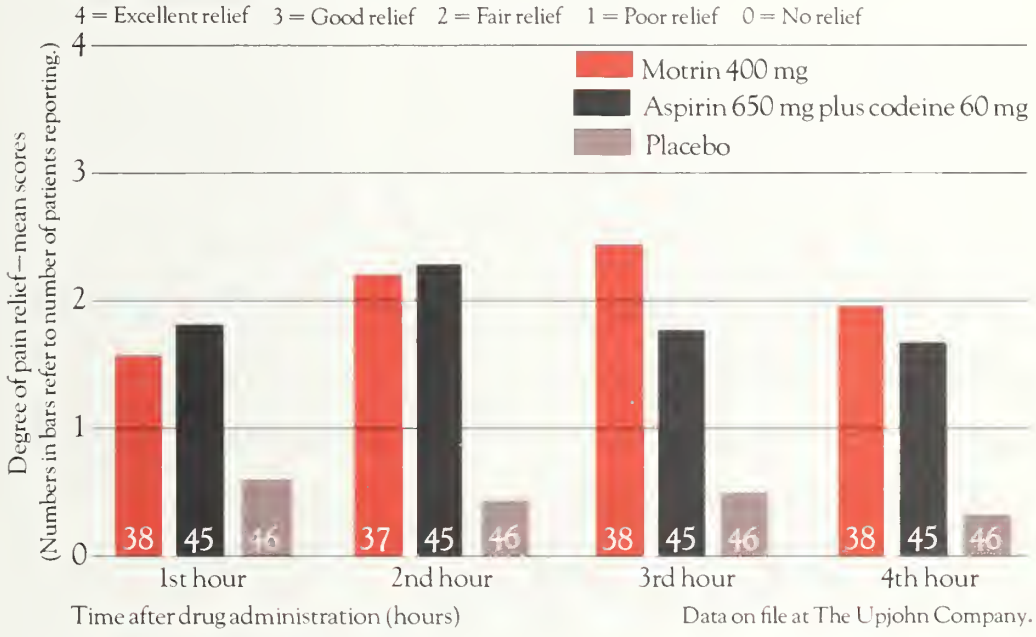


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compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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J-7835-4 May 1980

Obituaries

MICHAEL BALOURDAS, M.D., Cleveland; Faculty of Medicine University of Athens, Athens, Greece, 1944; age 63; died December 17; member OSMA and AMA.

HENRY E. BOEHMER, M.D., Cleveland; Case Western Reserve University School of Medicine, 1940; age 65; died January 10; member OSMA and AMA.

BERTIE B. BURROWES, M.D., Youngstown; Howard University College of Medicine, Washington, D.C., 1937; age 68; died January 14; member OSMA and AMA.

HOMER DEETER CASSELL, M.D., Dayton; Case Western Reserve University School of Medicine, 1921; age 84; died December 26; member OSMA and AMA.

LOUIS FEID, M.D., Clarksdale, Mississippi; University of Cincinnati College of Medicine, 1911; age 92; died December 30; member OSMA and AMA.

ROBERT K. FINLEY, M.D., Oregonia; Jefferson Medical College, Thomas Jefferson University, Philadelphia, 1916; age 89; died January 3; member OSMA and AMA.

GILBERT J. GORDON, M.D., Middletown; Washington University School of Medicine, St. Louis, 1966; age 40; died December 12; member OSMA and AMA.

RAYMOND A. HALL, M.D., Youngstown; Case Western Reserve University School of Medicine, 1931; age 74; died December 25; member OSMA and AMA.

ROBERT E. HOPKINS, M.D., Coshocton; Case Western Reserve University School of Medicine, 1928; age 76; died January 13; served as a Councilor for District 7; member OSMA and AMA.

ROBERT M. JOHNSON, M.D., Portsmouth; Jefferson Medical College, Thomas Jefferson University, Philadelphia, 1945; died January.

GRACE M. JORDAN, M.D., Columbus; Ohio State University College of Medicine, 1924; age 79; died December 31; member OSMA and AMA.

HENRY W. LEHRER, M.D., Sandusky; Ohio State University College of Medicine, 1916; age 90; died December 26; member OSMA and AMA.

VICTOR H. MAHAN, M.D., Pompano Beach, Florida; Ohio State University College of Medicine, 1928; age 76; died December 2; member OSMA and AMA.

ANTANAS MILIAUSKAS, M.D., Eastlake; Vytauta Didziojo University of Medicine, Kaunas, Lithuania, 1932; age 75; died January 4; member OSMA and AMA.

WILLIAM J. NEAL, M.D., Archbold; Temple University School of Medicine, Philadelphia, 1938; age 70; died December 30; member OSMA and AMA.

HAROLD A. ROBINSON, M.D., Ft. Myers, Florida; Case Western Reserve University School of Medicine, 1937; age 67; died December 26; member OSMA and AMA.

CYRIL E. SCHRIMPF, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1927; age 79; died December 31; member OSMA and AMA.

HUBERT H. SHOOK, M.D., Mesa, Arizona; University of Cincinnati College of Medicine, 1921; age 84; died July 14, 1979; member OSMA and AMA.

ALCINES C. SIDDALL, M.D., Oberlin; Case Western Reserve University School of Medicine, 1922; age 83; died December 11; member OSMA and AMA.

GEORGE C. TEDROW, M.D., Crooksville; Ohio State University College of Medicine, 1928; age 76; died December 7; member OSMA.

Fertility rate still low

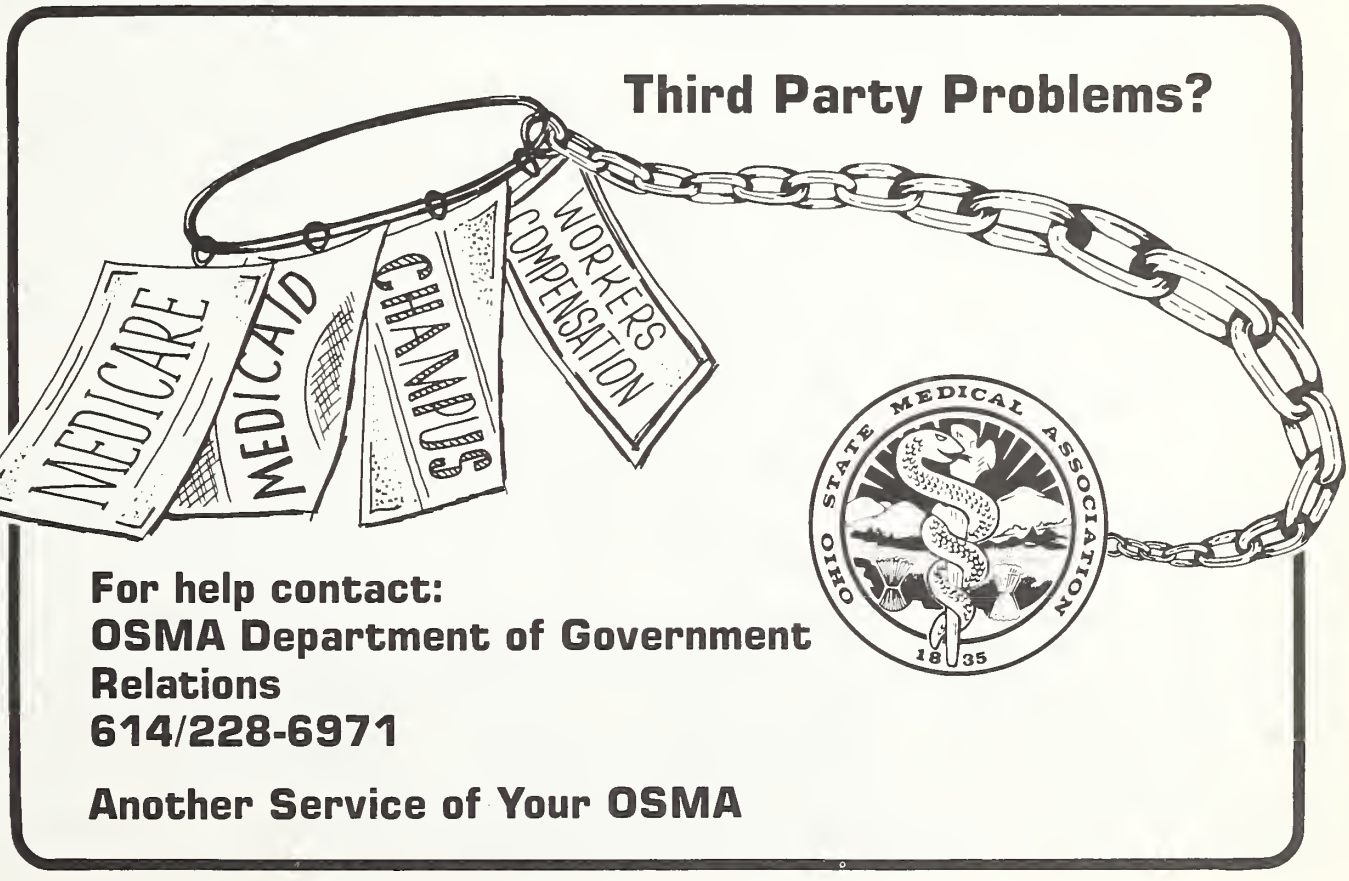
The fertility rate of American women continues at a low level, the U.S. Census Bureau reported this month.

The report noted, however, that there is considerable debate among experts in the field as to whether the trend is likely to continue.

The study showed that as of June 1979, the average number of births anticipated per married woman was 2.2. That was unchanged from 1975, but down from 2.4 in 1971, and 2.9 in 1967.

The report notes that "It is not certain whether the recent stability in birth expectations is transitional and will lead to further declines in fertility, or whether it indicates a new demographic trend in the United States."

The study notes, however, that there has been a large increase in the number of women in their early 30s who expect to have a baby within the next five years. — *From the AMA News*





CONTINUING EDUCATION PROGRAMS

MAY

26TH ANNUAL MEETING OF THE OHIO CHAPTER, ACS: May 7-9, 1981, Quaker Square Hilton Inn, Akron; sponsor: Akron City Hospital; 10 credit hours; fee: members $35, nonmember physicians $70, residents, interns, nurses, office personnel free of charge; contact: Vickey McVay, Ohio Chapter, ACS, 600 South High Street, Columbus 43215, phone: 614/228-6971.

MANAGEMENT OF THE GERIATRIC PATIENT WITH LOW VISION: May 9; Medical College of Ohio; sponsor: Medical College of Ohio; cosponsors: University of Toledo, Dept. of Special Education; Ohio Board of Regents; 7 credit hours; fee: $50, no charge to students or residents; contact: Charles E. Jaeckle, M.D., Medical College of Ohio, Division of Ophthalmology, C. S. No. 10008, Toledo 43699, phone: 419/381-4518.

NEW PROSPECTIVES IN ENDOCRINOLOGY - DIABETES AND THYROID DISEASE: May 13; Imperial House North, Dayton; sponsor: Wright State University School of Medicine; 4 credit hours; fee: $40 Wright State faculty, $50 others; contact: Ms. Arlene Polster, Wright State University School of Medicine, Box 927, Dayton 45401, phone: 513/372-7140.

TWENTY-THIRD ANNUAL REFERESHER COURSE IN DIAGNOSTIC ROENTGENOLOGY: May 26-30; Netherland Hilton, Cincinnati; sponsor: University of Cincinnati Medical Center; 35 credit hours; fee: $275; contact: Harold B. Spitz, M.D., 234 Goodman Street, Dept. of Radiology, Cincinnati General Hospital, Cincinnati 45267, phone: 513/872-4396.

UPDATE ON NEURO-OPHTHALMOLOGY: May 29-30; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $170; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

JUNE

SPINAL CORD MONITORING: FUNDAMENTAL AND CLINICAL APPLICATION: June 1-2; Cleveland-Hopkins Airport/Mariott Inn, Cleveland; sponsor: Case Western Reserve University School of Medicine; 12 credit hours; fee: $250; contact: M. M. Packard, Lakeside Hospital, Room 2529, 2074 Abington Road, Cleveland 44106, phone: 216/444-1614.

RESPIRATORY CARE UPDATE: June 4-5; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $120; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 X 28-cm (8 12 x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** *A short* (100-word maximum) abstract should be included with the article. It should cover the main points so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's last name and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2.Doe J. Roe RX: How to go about it. Ohio State M J 13:24-30, 1920"

Each textbook reference should include, in this order. Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5.Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

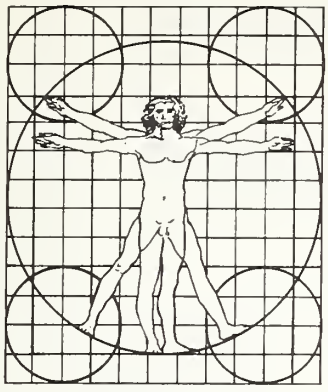
8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at $2 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. *The Journal* does not profit on reprint orders.

12. **EDITORIAL ASSISTANCE.** Ms. Carol J. Wiley, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association 535 North Dearborn Street, Chicago, Illinois 60610.



CLINICAL & SCIENTIFIC

STAGE OF GESTATION OF INTRAUTERINE EXPOSURE TO DIETHYLSTILBESTROL

Thomas G. Kirkhope, M.D.

In 33 patients with a history of intrauterine exposure to diethylstilbestrol (DES), exact drug histories from prenatal records of mothers were reviewed. An attempt was made to correlate total drug dosage with the presence or absence of objective colposcopic findings in the vagina and/or cervix of the patients. Total drug dosage could not be shown to be related to outcome. However, stage of gestation at which the patient was exposed was found to have significance. Twenty-seven of 28 patients with positive findings had been exposed during the 16th to the 20th weeks. None with negative or equivocal findings had been exposed during this period. Appropriate embryologic considerations are discussed.

IN 1971 HERBST[1] FIRST DESCRIBED the association between in utero exposure to DES, and the appearance of adenocarcinoma of the vagina in young women. Since then, a great deal has been learned about the benign and malignant changes brought about by the use of this drug during pregnancy.

In the Toledo area, no organized effort had been undertaken to find and identify young women with a history of DES exposure in utero. Therefore, in May of 1978, the author undertook an advertising campaign through local radio, TV, and newspapers, to invite young women with this history in for examination.

One hundred fifty-nine women responded, and all were interviewed and examined by the author. Where possible, documentation was obtained from their mothers' physicians' records as to dose, duration, and stage of gestation when the drug was used. As many other researchers have found, documentation was extremely difficult and many physicians' records were unobtainable. However, no patient responding to the advertisements was refused examination.

Of the 159 women, only 46 were able to produce written documentation from physicians' records of DES use during their mothers' pregnancies. Of these 46, 33 records were clear and detailed enough so that a reasonably accurate assessment could be made of total dosage, stage of gestation, and duration of use. In the remaining 13, use of the drug was documented in the physicians' prenatal progress record, usually when its use was initiated. In most, however, no mention was made about the time it was discontinued. In a few, the notation "Smith and Smith regimen" was found.

In reviewing Smith and Smith's original article,[2] it is found that the recommended regimen was quite complex. The amount of drug was increased gradually according to a predetermined formula throughout gestation and finally discontinued at 37 to 38 weeks. In these records no determination could be made as to how closely this plan was followed. Therefore, these patients were eliminated from consideration.

Twenty-eight of the 33 patients with accurate documentation had objective colposcopic findings related to DES effect, as described by Stafl,[3] Sandburg,[4] and Herbst.[5] Four had colposcopically normal-appearing vaginas and cervices. In one, findings were equivocal. The drug histories on these patients were matched with the findings, and the following results obtained.

Total dosage of drug given in patients with positive findings ranged from 840 mg to 44,800 mg and averaged 7,444.8 mg (mean = 7,444.8, median = 21,140, mode = 2,500). Total dosage of drug given in patients with negative findings ranged from 420 mg to 1,500 mg and averaged 830 mg (see table). Although the amount of drug appears lower in patients with negative findings, no conclusion can be drawn since the sample of patients with negative and equivocal findings is too small for statistical analysis (Fig. 1).

In reviewing stage of gestation, the following facts were noted. Use of DES was initiated at many different times during the pregnancy, usually in response to a bleeding episode. In some, however, the drug was begun very early because of a history of previous pregnancy losses. (In one, it appeared to have been started with the onset of the last menses. One wonders how this patient could have ovulated.)

Figure 2 is a bar graph showing drug use in the 29 patients with positive findings. Figure 3 represents an interpretation of these data indicating that in these 29 patients the peak inci-

From the Northwest Ohio Regional Perinatal Center at The Toledo Hospital.
Dr. Kirkhope, Toledo, Active Staff and Director of Medical Education for OB-GYN, The Toledo Hospital; Clinical Assistant Professor, Department of Obstetrics-Gynecology, Medical College of Ohio at Toledo.
This study was supported by a research grant from The Toledo Hospital.
Reprint requests to Northwest Ohio Regional Perinatal Center at The Toledo Hospital, 2142 North Cove Blvd., Toledo, Ohio 43606.
Submitted May 15, 1980.

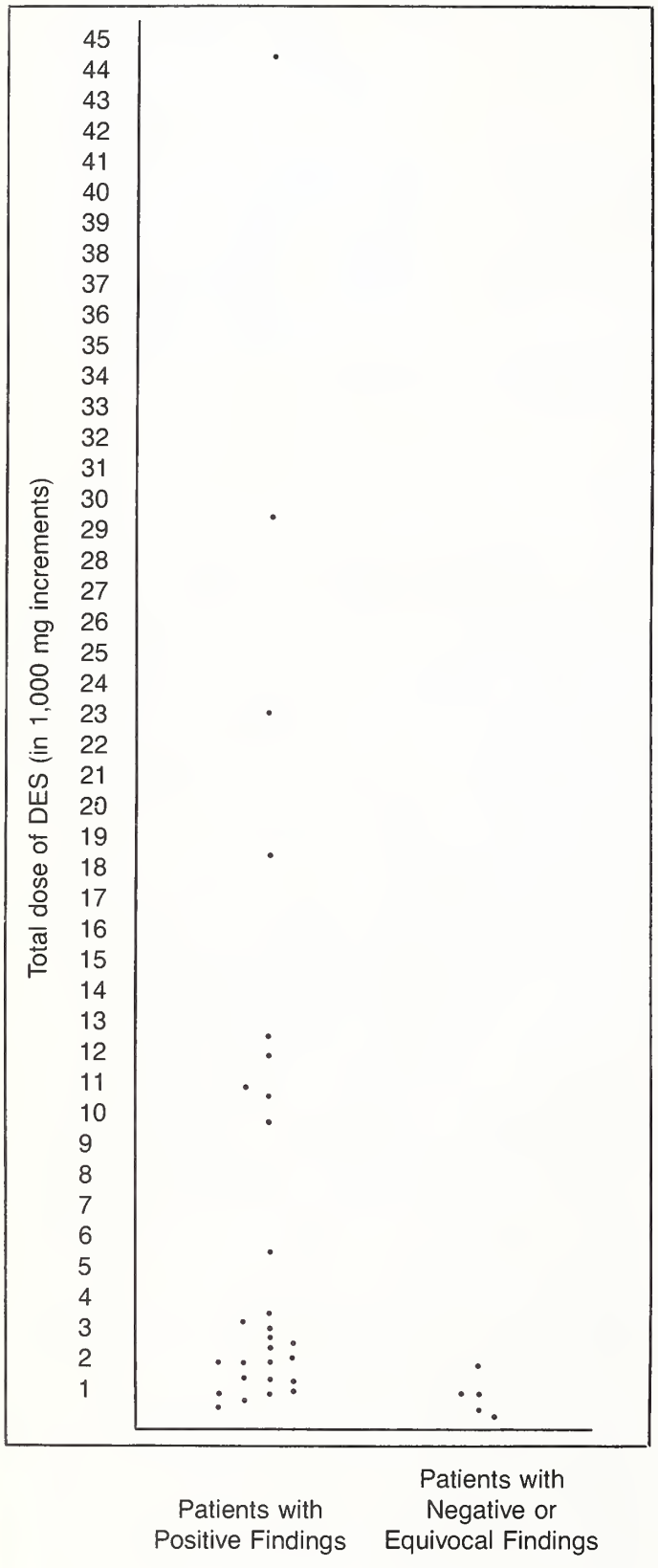


FIG. 1. Total amount of DES given during gestation.

Total Dosage of DES to which patients were exposed in utero

Patients with Positive Findings

1. 12,285 mg
2. 10,800 mg
3. 3,350 mg
4. 1,780 mg
5. 900 mg
6. 9,900 mg
7. 2,100 mg
8. 23,250 mg
9. 2,240 mg
10. 1,085 mg
11. 920 mg
12. 1,060 mg
13. 875 mg
15. 29,400 mg
16. 44,800 mg
17. 2,450 mg
18. 2,100 mg
19. 2,450 mg
23. 3,150 mg
24. 5,100 mg
25. 10,710 mg
26. 1,970 mg
27. 11,900 mg
28. 2,950 mg
29. 18,200 mg
31. 1,050 mg
32. 840 mg
33. 770 mg

Patients with Negative or Equivocal Findings

14. 840 mg
20. 560 mg
21. 1,500 mg
22. 420 mg
30. 875 mg

dence of drug use was during the 16th through the 20th weeks. Twenty-six mothers were on the drug throughout this period. One discontinued use in the 16th week, and another initiated its use in the 17th week. Only one patient's initiation and discontinuation of use of the drug were entirely remote from the 16- to 20-week period. (In this patient, however, the record shows use of the drug was initiated in the seventh week. It is not mentioned after the 12th week, nor is it specifically stated that the drug was discontinued. It is possible that this patient also may have continued using the drug during the 16th to the 20th weeks and beyond.)

Among the women with negative or equivocal colposcopic findings, no patient's mother was found to have used the drug during the 16th to the 20th weeks (Fig. 4).

Discussion

In embryonic life, the caudal ends of the paramesonephric ducts fuse in the midline to form what eventually will become the uterus, at about 60 days of life. The fused tubes grow in a caudal direction and come in contact with the dorsal aspect of the urogenital sinus. Here, the Mullerian Tubercle, (the caudal end of the fused paramesonephric ducts), meets the sinovaginal bulbs (an elevation in the posterior wall of the urogenital sinus), to form the vaginal plate. The Mullerian Tubercle then canalizes and eventually breaks through to form the vagina, upper and lower portions.



FIG. 2. Stage of Gestation and Duration of Drug Use in Patients With Positive Findings

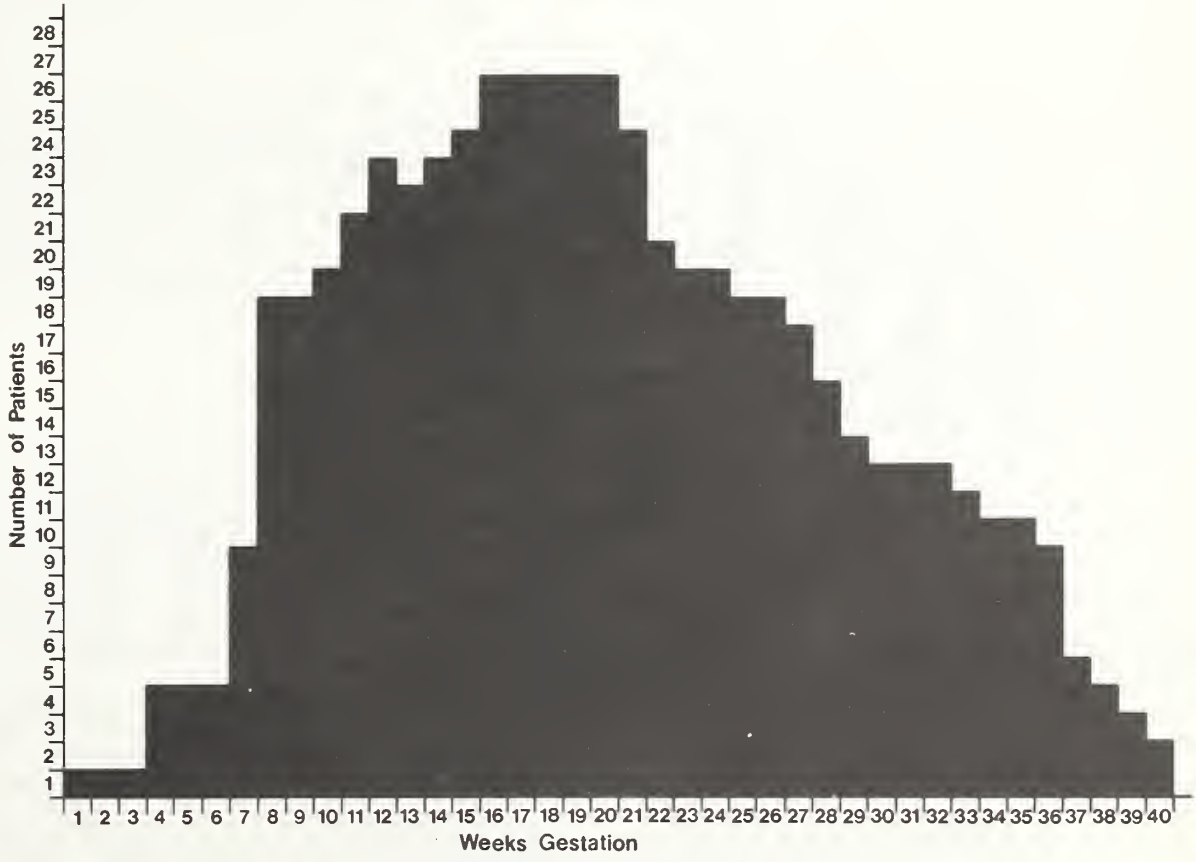


FIG. 3. Frequency of DES Administration at Various Stages of Pregnancy

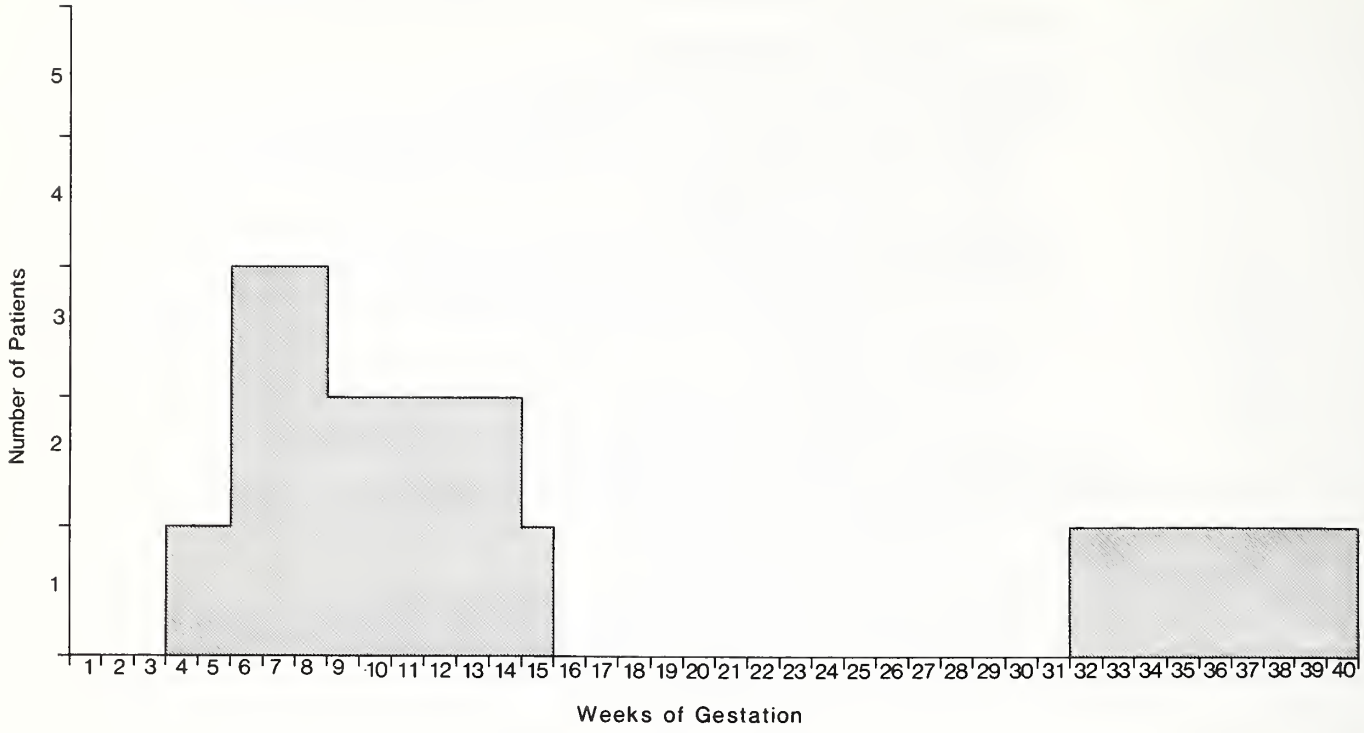


FIG. 4. Patients With Negative or Equivocal Findings
Duration of Treatment
(Total 5)

It is not certain what portion of the vagina each of these embryonic structures contributes, but it is thought that the distal two thirds of the vagina arises from the urogenital sinus, and the proximal one third, along with the cervix and uterine corpus, form the Mullerian system.[6,7] This chain of events is known to occur between the 16th and 20th weeks of intrauterine life (100 mm to 130 mm stage), which corresponds closely to the time DES was administered to the majority of the patients in this study.

We can speculate, then, that the synthetic estrogen, or one of its metabolic products, exerted its effect on the developing female genital system at a crucial time to effect the cervicovaginal differentiation. The result could have been a retardation or arrest of development of the vaginal plate. Using the same reasoning, one would expect medication given at an earlier time to have an effect on the Mullerian system higher up, since this portion was formed earlier in intrauterine life. Eventually investigation may show that anomalies of the upper reproductive tract are found more frequently among those daughters exposed earlier.

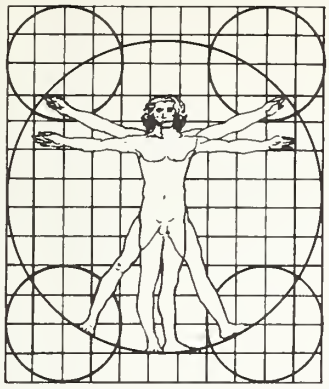
As was shown in this study, exact amount of drug given to mothers, as well as duration and stage of gestation, are extremely difficult to determine even when physicians' records are available. Therefore, answers to some of these questions may take many more years to determine, or may never be determined beyond the point of conjecture.

Summary

Twenty-eight young women exposed to DES in utero were found to have colposcopically identifiable changes in the epithelium of the vagina and/or cervical portio. Twenty-seven of these were found to have been exposed during the 16th to the 20th weeks of gestation, the time when differentiation of the vaginal plate is known to occur in embryonic life. Of five women with negative or equivocal colposcopic findings, none were found to have been exposed during this period. Total dose of drug could not be shown to have any correlation to findings.

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CLINICAL & SCIENTIFIC

ADRENAL CORTICAL RESERVE IN SYSTEMIC LUPUS ERYTHEMATOSUS

Thomas E. Currie, D.O.
David Ilfeld, M.D.
Randall S. Krakauer, M.D.

Eight patients with idiopathic systemic lupus erythematosus, none of whom had previously received corticosteroids, were stimulated with Cortrosyn to assess adrenal cortical reserve status in varying states of underlying disease activity. No evidence of adrenal cortical insufficiency was demonstrated.

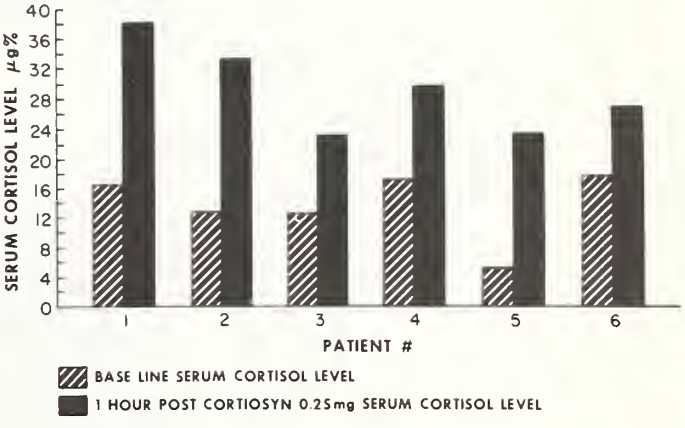
SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) is an autoimmune disease of unknown cause. There has been some evidence of an association of this with adrenalitis or adrenal cortical insufficiency.[1] Even if this were a common situation, it may be clinically difficult to describe or document due to the widespread use of corticosteroids in this disease. We therefore undertook a pilot study to evaluate adrenal cortical reserve in SLE patients prior to their receiving any corticosteroids.

Materials and Methods

Eight patients with SLE meeting four of the American Rheumatism Association criteria for the diagnosis of SLE, and having antinuclear antibodies, were admitted to the Cleveland Clinic Hospital for disease flare or diagnostic procedures. None of the patients had received glucocorticoid therapy. A baseline serum morning cortisol was obtained on each patient, followed by the administration of 0.25 mg of Cortrosyn intramuscularly. A second serum cortisol level was obtained one hour after this injection.

Results

As seen in the figure, all morning baseline serum cortisols were above 5 mg% and all levels obtained one hour after stimulation were at least double that of the baseline with the exception of patients 4 and 6. Each of these, however, had a one-hour post-Cortrosyn serum cortisol level above 20 mg% which is considered normal.



From the Department of Rheumatic and Immunologic Disease, The Cleveland Clinic Foundation, Cleveland, Ohio 44106, and the Department of Internal Medicine, Shaare Zedek Hospital, Jerusalem, Israel.
Dr. Currie, Bay Village, Chairman, Department of Medicine, Bayview Hospital.
Dr. Ilfeld, Jerusalem, Israel, Chairman, Clinical Immunology, Shaare Zedek Medical Center.
Dr. Krakauer, Cleveland, Head, Section of Clinical Immunology, The Cleveland Clinic Foundation.
Submitted August 15, 1980.

Discussion

There are few anecdotal reports of the association of Addison's disease and SLE in the literature,[2] although idiopathic Addison's disease is known to be associated with other autoimmune disorders such as Hashimoto's thyroiditis, hypoparathyroidism and pernicious anemia. Even if it were frequently associated with SLE, it might prove difficult to document due to the widespread use of corticosteroids in this disease. Indeed it is possible clinical signs of adrenal cortical insufficiency would be taken to represent "SLE flare," masking the true nature of the disorder.

The fact that the proliferative response of T lymphocytes to autologous human B lymphocytes is ablated by physiologic concentrations of hydrocortisone sodium succinate[3] provides evidence that glucocorticoid may play a role in physiologic regulation of autoimmunity. Finally, Berezhnaya reported 17 of 30 patients with SLE who, after ACTH stimulation showed low 17-hydroxycorticosteroid levels in the blood.[1]

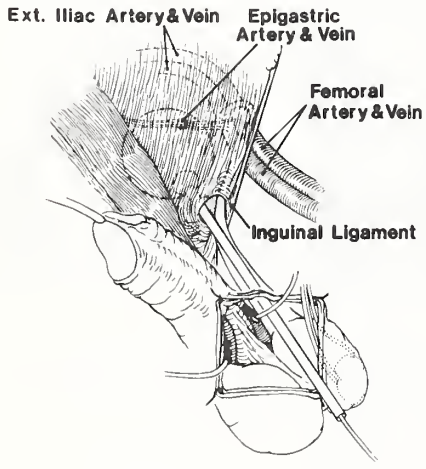
Our results do not demonstrate adrenocortical insufficiency in eight randomly selected SLE patients. It remains possible such an association exists at a frequency less than we likely would have picked up with the number of patients studied here. Nonetheless, we believe that were this association to be present, its incidence is not astonishingly high, and it is entirely possible that the small number of previous reports may represent the fortuitous association of two diseases in the same patient.

References

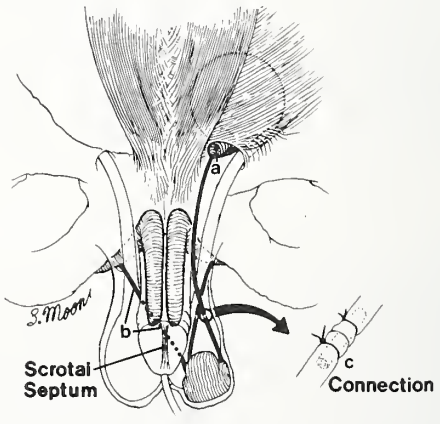
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Correction

The February issue of the Journal incorrectly transposed the descriptions of illustration 6 and illustration 8 in the article titled, "The Contemporary Surgical Management of Erectile Impotence." The descriptions should have been printed as below.



(Fig. 6) The Reservoir is Placed in the Intra-Abdominal Extraperitoneal Space with the Scott Reservoir Inserter.



(Fig. 8a) The Reservoir Tip Seats in the Endopelvic Fascia Defect.

(Fig. 8b) The Tubing from the Pump to the Right Penile Cylinder Passes Through the Scrota Septum to Prevent Torsion.

(Fig. 8c) The Technique for Tubing Connection is Illustrated.

THE Ohio STATE Medical Journal
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Features

This month's issue devotes itself to the subject of drugs, medicine's most powerful ally in its fight against pain and disease — and to the human factor which becomes involved with these "medical allies," either as patient or prescriber. The contents have been divided into three sections: Drugs, the Human Factor, and the Equalizers. Each section attempts to shed some new light on a subject which is probably as old as the practice of medicine itself.

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Letters ...to the editor

To the Editor:

Your article on Medicaid in the February 1981 issue provides misleading information regarding reimbursement.

In the section entitled "Reimbursement" on page 76, the article recommends that physicians bill under their customary charges because these are "used to update the department's usual and customary charge profiles maintained on each Medicaid provider, and while Medicaid is aware that often the usual and customary charge of the physician exceeds the Medicaid maximum, the data is needed to increase reimbursement levels."

This infers that the Medicaid reimbursement levels are undergoing periodic review and increase when in fact they are not. With the exception of a few procedures, such as office visits, the reimbursement level for most major procedures has not been increased for years. For example, the reimbursement for a routine delivery has been at the same level since before 1972.

I believe the fact is that any additional monies invested in the Medicaid program in recent years has gone to support expanding Medicaid roles, full reimbursement to hospitals and nursing homes, and support of worthless mandated programs such as EPSDT. Very little has been expended in increasing reimbursement levels to physician providers.

In 1975, the Medicaid reimbursement rate averaged 80% of charges. As fees have increased and reimbursement levels remained constant, the average reimbursement rate has dropped to 55%. The difference, of course, is being borne as a "hidden tax" through fee increases to the private paying population.

I urge that you research and prepare a follow-up article that summarizes the history of reimbursement rates to physician providers over the past decade, and compares the rates of reimbursement to physicians with that provided to other health care providers. I believe you will find the facts to reveal that physician providers are receiving a disproportionately small percentage of Medicaid monies available.

Sincerely,
/s/**Robert E. Daniel**
Administrator
Holzer Clinic Ltd.

Editor's Note: Officials of the Medicaid department who authored the original article have been invited to prepare a follow-up article.

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COLLEAGUES IN THE NEWS

RONALD C. AGRESTA, M.D., Steubenville, was elected president of the Ohio Valley Hospital medical staff. Dr. Agresta is an ophthalmologist and surgeon.

HARRY W. HAVERLAND, M.D., was elected president-elect and **MICHAEL P. GINNAMORE, M.D.,** secretary-treasurer.

I. LEONARD BERNSTEIN, M.D., Cincinnati, was named president-elect of the American Academy of Allergy. Dr. Bernstein is Director of the Allergy Research Laboratory, Allergy Training Program, Division of Immunology and Clinical Professor of Medicine at the University of Cincinnati Medical Center.

HENRY G. CRAMBLETT, M.D., Columbus, is the first chairman of the Accreditation Council for Continuing Medical Education. Dr. Cramblett is a professor in the department of pediatrics and vice-president for health sciences at Ohio State University. He is also active in numerous medical societies and associations.

AMASA B. FORD, M.D., Cleveland, was appointed Case Western Reserve University School of Medicine's first associate dean for geriatric medicine. Dr. Ford is professor of community health and family medicine at Case Western.

LEONARD GAYDOS, M.D., Tiffin, was reelected president of Mercy Hospital's medical staff. **ADOEBEN MONTESCLAROS, M.D.,** was elected vice-president and **SERI KAOSOL, M.D.,** secretary.

ROGER GOVE, M.D., Columbus, was appointed to a three-year term on the Franklin County Board of Mental Retardation and Development Disabilities.

ROBERT E. GREGORY, M.D., Cincinnati, was elected president of the medical and dental staff of Children's Hospital Medical Center. Dr. Gregory is a clinical professor of pediatrics at University of Cincinnati's College of Medicine.

H. R. HITTNER, M.D., Dayton, was elected chief of staff at Good Samaritan Hospital.

GILBERT WAYNE HOPKINS, M.D., Dayton, was elected chief of staff at St. Elizabeth's Medical Center.

THOMAS JOYNES, M.D., Mayfield Heights, was elected president of the Windsor Hospital medical staff. **PHILOMENA LUCZEK, M.D.,** Solon, was elected vice-president.

The Governor's Award, the state's highest honor, was presented to **WILLIAM S. KISER, M.D.,** Cleveland, and **TIMOTHY MORITZ, M.D.,** Portsmouth. Dr. Kiser is chairman of the board of governors of the Cleveland Clinic Foundation. Dr. Moritz is former director of the Ohio Department of Mental Health and Retardation.

NERMIN LAVAPIES, M.D., was elected president-elect, and **PATRICK ARAKAWA, M.D.,** secretary-treasurer of Martins Ferry Hospital.

LARRY LeFEVRE, M.D., Piqua, was elected president of the Dettmer Hospital medical staff. Dr. LeFevre is in the practice of adult internal medicine. **JASEEM PASHA, M.D.,** was elected vice-president and **E. ROBERT TORRENCE, M.D.,** secretary-treasurer. Dr. Pasha is a psychiatrist and Dr. Torrence is a radiologist.



I. Leonard Bernstein, M.D. . . . new president-elect of the American Academy of Allergy



Timothy Moritz, M.D. . . . recipient of the Governor's Award

ROBERT MALTZ, M.D., Cincinnati, was elected secretary-treasurer of the American Association of Cosmetic Surgeons.

FRANCES A. MILLER, M.D., Youngstown, will head the American Cancer Society's service and rehabilitation committee. Dr. Miller is retired from active practice but is a member of the Youngstown Hospital Association medical staff, the Mahoning County Medical Society and numerous other professional organizations.

FREDERICK P. ZUSPAN, M.D., Columbus, was named president-elect of the International Society for the Study of Hypertension in Pregnancy. Dr. Zuspan is chairman of the department of obstetrics and gynecology at Ohio State University.

FEDERAL

REAGAN HEALTH BUDGET

The budget of the Reagan Administration which is before Congress contains about $49 billion in cuts. While taking substantial cuts, HHS is not taking as great a percentage cut as other Departments, due primarily to the "Social Safety Net" programs in the Department. While the average Department cut is 13.4% (excluding Defense), the HHS budget will be cut only 3.5%. In fact, HHS will still be receiving a $21.7 billion increase between FY81 and FY82. Staff at HHS is targeted for a reduction of 1,000 full-time equivalents.

Of major interest will be the block grant programs to the states under which the federal government will end most of the health categorical grant programs, transferring a part of the funds to the states.

FDA — The FDA has remained relatively untouched.

Health Service Administration — Major cuts will be taken here with large portions of the Agency's activities placed into block grants or being eliminated. Going to **block grants** will be: Community Health Services; Migrant Health; High Blood Pressure Control; Home Health; Maternal and Child Health; EMS; and Genetic and SIDS Research and Screening. PHS hospitals will be closed. Merchant Seamen Entitlement will be eliminated. Medical services for Coast Guard and PHS officers will be on a contract basis.

National Health Service Corps — Corps field strength will be allowed to grow to 2,500 and held there. A $4 million cut will be requested to eliminate certain pay bonuses to obligated Corps physicians.

National Health Service Corps Scholarship — No new awards. Funds will be available for continuation for those already receiving scholarships.

Maternal and Child Health Research and Training — Funds will be eliminated. The budget indicates funds are available from other sources including NIH.

Centers for Disease Control — Mostly minor cuts in programs to remain at CDC, but the Centers will loose major programs to block grants including: Health Incentive Grants; Health Education; VD; Immunization; Fluoridation; Rat Control; and Lead-Based Paint Poisoning. Targeted for a $5 million cut will be the National Institute for Occupational Safety and Health (NIOSH).

NIH — No real cuts here, but programs will not be allowed to increase to meet inflation.

Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) — Major cuts here with large program areas being transferred to the Health Services block grant. Indirect support for educational institutions make up the bulk of the remaining cuts.

Health Resources Administration — As reported, state and local **health planning** funds will be eliminated over a two-year period. **Health manpower** shows almost a total elimination of institutional support. Primary Care/Family Medicine will receive $44 million (down from a FY80 level of $65 million). AHECs will be cut $5 million to $16 million. Nurse training will take a major cut from $83 million in FY80 down to $14 million in FY82.

Office of Assistant Secretary for Health — Two block grants will be placed here for Administration. The **Health Services** block grant will be funded at $1 billion 139 million (replacing $1.5 billion) and the Preventive block grant will be funded at $261 million (replacing $380 million). **Health Services Research and Health Technology Assessment** will be rolled together and suffer a combined cut of $15 million to $20 million. **HMO** funds will be phased out over two years ($54 million in 1980; $8 million in 1982). The **Adolescent Pregnancy** program will be placed in the Prevention block grant.

HCFA — As previously reported, the Administration will propose a cap on federal expenditures for Medicaid for a 1982 savings of $1 billion. New is the repeal of certain changes made by last year's budget reconciliation bill (PL 96-499). Included is a repeal of the one-month shift in hospital Periodic Interim Payment, increased home health benefits, expanded dental services and the pneumococcal vaccine program (savings of $736 million). The plan also calls for a savings of $105 million from legislation to service reimbursement for kidney dialysis by allowing only a single rate based on freestanding facilities. **PSRO** is slated to end by 1984. The budget calls for $135 million in FY81 and $70 million in FY82. Also, Utilization Review will be eliminated.

TWO NEW HEALTH BLOCK GRANTS

The Department of Health and Human Services (HHS) has developed two draft bills designed to implement a part of the Reagan Administration's proposal to replace the public health categorical grants with a block grant program.

One of the draft bills establishes a Preventive Health Block Grant ($261 million) and would provide for an allotment to each state based on the percentage of total preventive health grant funds each state currently receives. Each state would be required to use its funds for health promotion and disease prevention activities. As a condition to receiving funds, states would have to demonstrate that they have maintained a child immunization program at a rate of immunization specified by the Secretary of HHS. Categorical grant programs that would be repealed and replaced by the preventive health block grant include: grants to state mental health programs, lead-based poison prevention, child and influenza immunization, rodent control, hypertension, fluoridation, venereal disease programs, family planning grants, genetic disease programs, adolescent smoking and alcohol use, and adolescent pregnancy programs.

The second bill would institute the same block grant approach in place of categorical grants in the area of basic health services and mental health and substance abuse services ($1.4 billion). The programs it would repeal include: hospital affiliated primary care centers, community

and migrant health centers, home health services, primary care research and demonstration projects, sudden infant death, hemophilia treatment and blood separation centers, emergency medical service grants, alcohol abuse program grants, drug abuse program grants, community mental health centers, maternal and child health and crippled children's services, clinical facilities for coal miners, and grant programs under the recently enacted Mental Health Systems Act.

Both bills prohibit use of grants for cash payments to intended recipients of health services and land purchase or building construction. Both bills also provide that states would be required to report on the use of funds, would require states to audit their expenditures, and would provide for GAO audits.

STATE

PEER REVIEW IMMUNITY EXTENDED

The OSMA was successful in amending House Bill 51 (J. Thompson, D-Cleveland) to provide qualified immunity from civil damages to persons who provide information "without malice" to peer review committees, hospital credentialing committees, or hospital utilization review committees. Currently, only members or employees of these committees are granted qualified civil immunity under Section 2305.25 of the Ohio Revised Code. HB 51 was originally introduced to extend this immunity to nursing home peer review committee members.

Stanley J. Aronoff (R-Cincinnati), Assistant President Pro Tempore of the Senate, greatly assisted OSMA by sponsoring the immunity amendment and expertly explained its importance to the members of the Senate. The amendment was approved unanimously and had the support of both the original sponsor of HB 51, House Health Committee Chairman John D. Thompson, and Senate Health Committee Chairman John Kasich (R-Columbus).

The legislation becomes effective 90 days after Governor Rhodes signs the bill.

MANDATED MEDICAID PROVIDER REIMBURSEMENT INCLUDED IN HOUSE BUDGET BILL

The Ohio House approved HB 167, the $9.3 billion budget bill for the State of Ohio for the fiscal year beginning July 1, 1981. The budget bill contains language, which if approved by the Senate and signed by Governor Rhodes, would require the Department of Public Welfare to pay all valid claims by physicians and other providers within 45 days after being received by the Department. Representative Michael Fox (R-Hamilton) introduced the 45-day payment amendment in the House Finance Committee. The amendment also requires the Department of Public Welfare to pay 10 percent interest on unpaid balances if the Department does not meet the 45-day deadline. The amendment to the budget permits a provider to file a civil action in court if the failure to pay a claim within the specified period of time results in the provider incurring additional damages, such as interest on a loan required to pay current operating expenses.

The budget bill traditionally has contained an appropriation for a two-year biennium. Due to the state's current financial condition and the uncertainty of revenue estimates, the Democratic-controlled House has taken Republican Governor Rhodes' two-year budget proposal and only acted on a bill based upon a one-year appropriation. The Republican-controlled Senate will be examining both the Governor's original two-year budget requests as well as the House-approved one-year version in early May.

HB 167 contains language that will increase physician fees for relicensure from the current fifty dollars every three years to one hundred dollars every two years. The change will bring the State Medical Board accounting procedure into accordance with the State's biennial accounting procedure. The increased fees will be used to increase the funding of the State Medical Board. This change was approved last session by the Senate and by the House Health and Retirement Committee in Senate Bill 368 but did not become law.

The OSMA Department of State and Federal Legislation will be monitoring the budget as it continues in the Senate and in the conference committee expected to convene to reconcile the differences between the House and Senate versions.

MEDICAL CARE FOR WARDS OF THE STATE

Under a new bill, HB 352, physicians treating wards of the state would be entitled to representation, immunity, or indemnification in any civil actions arising from their services. Introduced by Rep. Charles R. (Rocky) Saxbe (R-Mechanicsburg), the bill has been referred to the House Health and Retirement Committee.

HB 352 would grant this entitlement to any physician, dentist, or psychologist who renders services to a ward of the state, either (1) under a personal services contract with a state agency, or (2) as a member of the staff of a state health care facility.

Following discussions with the OSMA, HB 352 was drafted by the Department of Rehabilitation and Corrections in response to concerns of Southern Ohio physicians who treat inmates of Ohio correctional facilities.

PHS Budget (Budget Authority in millions)

	1980	1981*	1982	Change
FDA	325	355	336	−19
Health Services Administration	2,066	2,071	878	-1,193
CDC	374	296	161	−135
NIH	3,429	3,512	3,762	+250
ADAMHA	1,112	998	443	−555
Health Resources Administration	577	305	234	−71
Assistant Secretary for Health	255	238	221	−17
Block Grants	(1,871**)	(1,727**)	1,400	+1,400

*Excludes $679 million proposed rescission.

**Comparable amounts for programs being replaced by block grants.



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Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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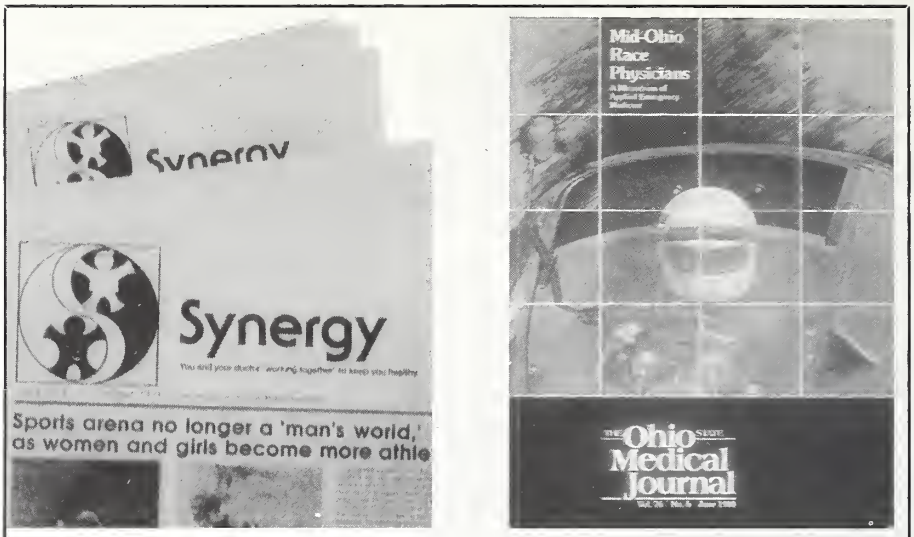
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• **Legal Aspects of Medical Practice** (LAMP), is a new monthly newsletter, designed to help physicians understand and manage legal and regulatory issues affecting their private or institutional practices. LAMP is an official publication of the American College of Legal Medicine, and is available on a subscription basis at an annual, 12-issue rate of $48 per year ($60 outside the U.S.). For more information, please contact: Legal Aspects of Medical Practice, 4-2 42-15 Crescent St., Long Island City, New York 11101.

• **Tension Headache** is the subject of a new full-color videotape, available for purposes of patient education from Medec, Inc. The videotape outlines the basic pathophysiology of the tension headache, as well as general treatment measures, and provides, Medec claims, the necessary credibility to a diagnosis which is often disbelieved. Further information may be obtained by writing Joanne Roger, R. D., Medec, Inc., 12815 120th Ave., N.E., Kirkland, Wa. 98033.



Synergy and . . . the Journal, a winning combination

OSMA publications receive awards, raves

Synergy and the *Ohio State Medical Journal* have recently been the recipients of several new honors and awards.

Synergy, OSMA's health education publication, received honorable mention in an annual medical journalism competition, sponsored by the Sandoz Pharmaceutical Company; and the *Journal* has captured two national graphic design awards, one for its June, 1980 cover of the race car driver, and one for the layout and design of the Boston Marathon story which ran in July 1980. June's cover was also singled out for attention recently, by New Hampshire graphic designer, Roger Patterson, who used it as an example of "outstanding photo treatments" in his newsletter for graphic artists, "The Board Report."

. . .And high-quality prenatal care for all

The American Medical Association is calling for an all-out national effort, on the part of physicians, government, and the public, to extend to nearly one fourth of the new mothers in the United States the same high-quality obstetric, prenatal care utilized by the other three fourths of new mothers each year.

In a report published in the March 20 *Journal of the American Medical Association*, the AMA Committee on Maternal, Adolescent and Child Health of the Council on Scientific Affairs outlines the problem and offers suggestions for a solution.

"Unfortunately, for a number of reasons, about one fourth of our new mothers do not (begin prenatal care within three months of pregnancy). One to two percent give birth with no prenatal care," the report said.

To meet this problem, the Committee recommended:

• Reaffirmation of the AMA's position regarding the importance of high quality obstetric and newborn care, and the need to make such care available to all women and newborns in the U.S.

• That executive and legislative branches of government be urged to consolidate all federal programs dealing with maternal and child health care services in a single office with budgetary authority.

• That state and federal government be urged to fund public programs sufficiently well to guarantee equal access to adequate care.

• Public education as to the long-term benefit of proper care and the hazards of inadequate care.

• That discussions continue on means of improving services for the medically indigent and the culturally displaced.

Health and social services combine for states' benefit

The Reagan Administration's current block grant proposal plans to consolidate nearly 40 categorical grants for health and social services, including such programs as community health centers, migrant clinics, emergency medical services, alcohol and drug abuse services, health incentive grants, venereal disease, and immunizations.

A block grant approach, explains the budget document, would give states greater flexibility and responsibility in selecting those service delivery agencies which are best able to provide certain services now provided by direct federal grantees.

"The overall result," it continues, "would strengthen state governments and provide publicly financed services more effectively and at lower costs to those in need."

BOOK SHELF

Psychotropic Drugs: Manual for Emergency Management of Overdosage. *By Nathan S. Kline, M.D. and Jean-Pierre Lindenmayer, M.D. Medical Economics Books.*

Called a "sell-out classic," this pocket size, flip-open manual begins by spelling out the emergency, life-saving actions for every major symptom of drug overdosage. Recommended treatment is in plain language, and actions that nonmedical personnel can take are boxed in color. Full-size, full-color photographs help in fast identification of psychotropic tablets and capsules.

This recently printed second edition is available for $15.95 per copy, plus $1.00 handling charge from: Medical Economics Books, Box 157, Florence, Kentucky 41042.

Selection and Interpretation of Diagnostic Tests and Procedures: Principles and Application. *Published by the American College of Physicians (ACP).*

This guide to the effective use of diagnostic tests is the first such handbook developed for the medical community. It is designed to help physicians select tests and therapeutic procedures in a cost effective manner, and to interpret results more efficiently. The manual appeared as a supplement to the April issue of the *Annals of Internal Medicine*, the official journal of the American College of Surgeons, but copies of the guide may be obtained at cost by writing the College's Department of Health and Public Policy, 4200 Pine Street, Philadelphia, Pa. 19104.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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REFER TO PDR

DRUGS

and the Human Factor

Drugs. Webster defines them as "a chemical substance, administered to a person. . .to prevent or cure disease; to enhance physical or mental welfare." They kill pain, ease tensions and for many, make life itself possible. They are numbered among medicine's most powerful allies in its fight against pain and suffering.

Yet along with this power to help and heal, there lies inherent in every pill, properties which can also weaken and destroy. Their ultimate use — or abuse — like the "infallible computer," depends on the human element involved.

Because it would be impossible to squeeze a thorough and comprehensive treatment of this subject into a 60-page format, this issue of the *Journal* will take a look at "Drugs and the Human Factor" — at those complications which can and do occur when the very human factor of physician, patient, pharmacist, and others enters the picture — and at those enforcement agencies which are often called upon to handle the resultant problems.

No blame is placed, no finger pointed. But by stating concerns and examining them objectively — by heightening awareness of the problems, perhaps drugs can be taken from the streets, dusted off, and returned to the medicine cabinet — where they belong.



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DRUGS

Beginning with the Basics

- Drugs and society: an overview
- Words of encouragement about drugs you prescribe
- The future of pharmaceuticals

DRUGS and SOCIETY:

An overview

By Joseph R. Bianchine, M.D.

During the past 25 years, a flow of new, effective drugs has been introduced to the medical scene. Physicians now have at their disposal a remarkable array of highly effective drugs. Unfortunately, physicians are faced also with many problems associated with drug use.

Louis Lasagna, M.D., Professor of Pharmacology at the University of Rochester, likened this recent availability of many new drugs to a pharmacologic revolution. As with many revolutions, significant beneficial impact is realized by many individuals, but as with all great revolutions, grievous injury has fallen heavily on at least a few. A small but significant number of patients experience problems with drugs — with any drug — no matter how commonly it is employed. These drug toxicities or side effects range from a minor rash, which may be merely annoying, to a severe fulminant reaction which may terminate in death within moments of taking a drug (acute hypersensitivity syndrome). However, given a choice between no treatment and effective treatment with a risk of toxicity, the modern physician must judiciously pick the latter. To paraphrase Emerson, "It is the fertile soil — not the barren — which breeds fevers, crocodiles and scorpions."

THE PROPER USE OF DRUGS

Drugs should not be used for trivial reasons — not to mention wrong reasons. Drugs ought not be prescribed casually by physicians. Controlled studies have demonstrated that sometimes the less a patient is treated, the better off he is. For example, several drug trials in medical literature clearly show that a placebo group of patients actually fared better than the group receiving the real drug. This occurred not only because the "real' drug had no therapeutic effect, but also because the "real" drug had very significant toxicities.

A second problem the physician must handle deftly, concerns the patient's desire to receive medication — any medication — to hasten the road to recovery. It is amazing to note how often a patient's desire to take pills sways the physician's decision to prescribe medication. The experienced practitioner of medicine down through the centuries has learned that a firm faith in drugs, brews, potions, and plasters, liberally administered, was a surer road to popular success than the more correct path of using drugs sparingly and only those of proven value. This is still true today.

A physician may utilize drugs effectively, yet avoid undesirable side effects by knowing the pharmacology of each drug he plans to administer and also by learning as much as possible about the patient in whom the drug is to be used. Both of these aspects are very important indeed. If a drug causes a bad effect once in 10,000 administrations, does this suggest that the drug is defective or does it mean that this patient is different or abnormal in some way?

SEVERAL "FACES" OF A DRUG

Insulin clearly illustrates some of the delicately balanced factors which must be considered by both the patient and the physician in the regulation of diabetes mellitus. Analogous factors surround the administering of other drugs as well. If too much insulin is given, blood sugar falls excessively and the patient can become comatose and die. If too little insulin is given, the disease can go out of control — blood sugar rises excessively, and a whole series of undesirable complications develop. Therefore, just the right dose of insulin is needed daily. But what is the correct dose? The need for insulin may decrease if exercise increases or food intake is diminished. The requirement for insulin increases as food intake increases, or with an infection. Luckily, physicians have specific tests of blood and urine sugar to help regulate the dose of insulin. If only similar tests were available to tell us what the correct doses of certain other drugs should be!

If problems occur from insulin use in the conscientious management of the severe diabetic, these reactions are termed toxic effects or drug side effects, but not drug misuse or abuse. Can insulin be abused or misused? Yes! A patient I know, a young woman from a broken home, uses her illness to manipulate her environment and her doctors. If she does not receive the attention she needs, she simply takes too much insulin, slips into hypoglycemic shock and is rushed to the hospital where she receives the attention she craves. All is well for a while. This process is repeated when the patient feels that the family needs a reminder. This is clearly misuse of a drug and has obvious dangers.

Another form of "drug abuse" has come about because patients have come to expect prompt cures from drugs, and feel cheated if drugs are not prescribed. Often their first words upon greeting the physician will be, "Doc, I need a shot of penicillin because. . ."

Joseph R. Bianchine, M.D., Ph.D., is an OSMA member and Chairman of the Department of Pharmacology at Ohio State University. The above text is taken from a handout he distributes to medical students.

"It is amazing to note how often a patient's desire to take pills sways the physician's decision to prescribe medication."

DRUGS AND SUICIDE

Another major misuse of drugs is their common use in suicide. Although central nervous system depressants are the most common class of drugs used in suicide, a variety of other drugs are utilized for this purpose. The patient's doctor, his minister, and his family may be unwitting partners in this tragedy. At a point of great emotional distress or despair, a patient may seek help. The doctor who fails to hear out the patient's complaints (this may require much time!) may fail to recognize the patient's cry for help as symptoms that are indicative of a potential suicide. All complaints may be attributed to "nerves" and sedatives are liberally prescribed. If these medications do not solve his personal or social problems (drugs usually do not solve such problems), the patient may simply ingest all the medication at once in a moment of despair. Even when a patient is recognized as a suicide risk and pills are prescribed judiciously in small numbers, patients have been known to hoard pills until a lethal supply is accumulated — then take them all. Obviously this risk is greater if the potential for suicide is not recognized.

DRUG ABUSE

While the uses and abuses of drugs briefly sketched above are significant medical problems, these sorts of problems do not make the newspaper and do not seem to concern our society much.

However, one sort of drug abuse that is not simply ignored, and does not escape the attention of society, is drug addiction. Why do certain people take narcotics or other drugs for nonmedical purposes?

There is no clear answer to this question. Only a small minority of patients exposed to narcotics in legitimate medical situations become addicted or even use narcotics occasionally once the medical problem is solved. Even among the socially deprived, relatively few individuals experiment with narcotics. And of those who do, most will not continue using them. Therefore, it is clear that these drugs have no mystical power locked within.

However, specific sorts of people seek out these drugs. While most individuals find narcotics dysphoric and unneeded, a few people seem to treasure the euphoric effects of narcotics. It has been suggested that there are no drugs, only drug addicts. This aphorism is partly true. Further, many addicts restlessly go from one drug to another — marijuana to heroin to alcohol to LSD — in search of pharmacologic solace, finding no drug "right." Why take narcotics? Bravado, defiance of society and desire for thrills may motivate some individuals. Individuals who take narcotics seem to desire to "get off the norm," to change his usual emotional, intellectual or perceptual set. The adolescent or teen addict may use drugs as an alternate to making decisions concerning vocation, education, or family.

The high cost of narcotics on the illicit market often is astounding. An addict may spend $100 a day, or more, for drugs. A young addict, unskilled and untrained, may turn to burglary or prostitution in order to provide enough money to support the "habit." Once addicted to narcotics, the individual has an unquestioned urge to continue taking narcotics. While the mechanisms for this phenomenon are not well understood, both physical and emotional dependence on these drugs do occur.

SOCIETY AND THERAPEUTIC PROGRESS

We must accept the fact that society must pay a price for therapeutic progress. Our job as physician is to see that the price is not too high.

Dr. Lasagna concluded a lecture on this very topic in the following way: "The mind of man has removed the stopper from the medicine jar. The chemical genie, formerly imprisoned within, now stands before us. He is a spirit known to work miracles, but also to create havoc — to improve life or destroy it. It is quite clear that we can never wish him back into the jar."

Services to those in need is a paramount motivation of physicians. Medicines represent the real and symbolic power of the physician. All the force of centuries of expectation, suggestion, and "magic" lies behind the physician's prescription.

The expectation that pills hold a key to happiness and relief from anxiety is supported by the real achievements of medical science. Powerful drugs such as the antimicrobials, analgetics, cardiac glycosides, tranquilizers, and others, support the general belief of the lay public that physicians also must have medication for the solution of difficult personal problems.

The physician has a crucial role in setting the public record straight. We have a unique opportunity to see individuals at the time when they most want relief from their distress. When the physician believes the distress presented by a patient represents a manifestation of a problem of daily living, he can refer the patient to the professional source that can assist the patient in the solution of his problems. To only mask these symptoms with medication may prevent the patient from recognizing them as the warning signals of a solvable personal life problem. OSMA

A leading pharmaceutical company speaks some

Words of Encouragement About the Drugs You Prescribe

By David L. Reynolds

In 1980 you and your colleagues put pen to paper 1.4 billion times to order for your patients one of the truly outstanding values of our time. . .the prescription drug.

Although drugs are still being abused and misused in today's society— problems which are addressed regularly in the professional and lay press — there are many positive aspects of pharmaceuticals that go virtually unnoticed. For example, life expectancy has increased from 47 years in 1900 to over 70 years in 1975. Although public health measures such as good sanitation and pure drinking water did much to improve life in the early 20th century, much of the improvement in life expectancy from 1930-1975 must be attributed to the fruits of biomedical research, primarily pharmaceuticals and biologicals.[1]

Economic gains, too, have been enormous. It is estimated that the public benefited to the tune of $57 billion between 1930-1975 by avoiding more expensive therapy and/or hospitalization.[2] Add to that the sums earned by those who otherwise would have lost wages due to illness, and the figure becomes almost incomprehensible.

To give a more digestible example, the British National Health Service recently estimated that effective treatment for the three disease categories of tuberculosis, mental illness, and chest disease, saves more than the **total** payments by NHS to pharmaceutical vendors.[3]

Despite charges of profiteering at public expense, prescription price increases have been far below the consumer price index (1967-1979) for all goods and services. Pharmaceutical manufacturers' prices increased 42% during that period of time, while prices in general went up 117%.[4] Prescription drugs account for little more than 5% of the total health care expenditure.

In 1960 it took patients an average of about two hours to earn the price of a prescription. In 1977 it took only about 50 minutes, making the medicinal products you prescribe an even better value today than they were in 1960.[5]

Unlike many industries, the developers of new prescription medicines finance their own research. Tax dollars are not used. Despite many obstacles and fewer incentives, the drug industry is spending $1.5 to $2 billion per year of their own money on research. Individual companies may invest up to $60 million and ten years researching and developing a single new product. Many new and better treatments are waiting in the wings to be introduced in the United States. Some predict another "golden age" of new therapeutic entities that will render many of today's most reliable products obsolete. For diseases for which no treatment exists, a whole

"Prescription drugs, with all of the problems to be overcome, may represent the best hope we have to contain health care costs."

David L. Reynolds is Manager of Professional Communications for Burroughs-Wellcome Company, and is heard regularly on the Florida and Georgia Radio Network as host of "A Visit With Your Pharmacist," a drug information program for lay audiences.

new world of chemotherapy will unfold.

Prescription drugs, with all of the problems to be overcome, may represent the best hope we have to contain health care costs. They are a direct, often measurable, effective, and even safe method of treating the conditions for which they are indicated. Nobody wants to be sick; nobody wants to pay to get well, but in terms of cost effectiveness the physician would be hard pressed to provide a better alternative to his patients except, perhaps, no treatment at all.

"Economic benefits are much more simple to quantify than the priceless commodities of comfort, peace of mind. . ."

We have talked about prolongation of life, but mostly we have talked about dollars. Economic benefits are much more simple to quantify than the priceless commodities of comfort, peace of mind, and a better "quality of life" in general.

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Grim statistics reveal some encouraging facts about the nature of drugs.

Table

Ten leading causes of death in the U.S., 1900 and 1975

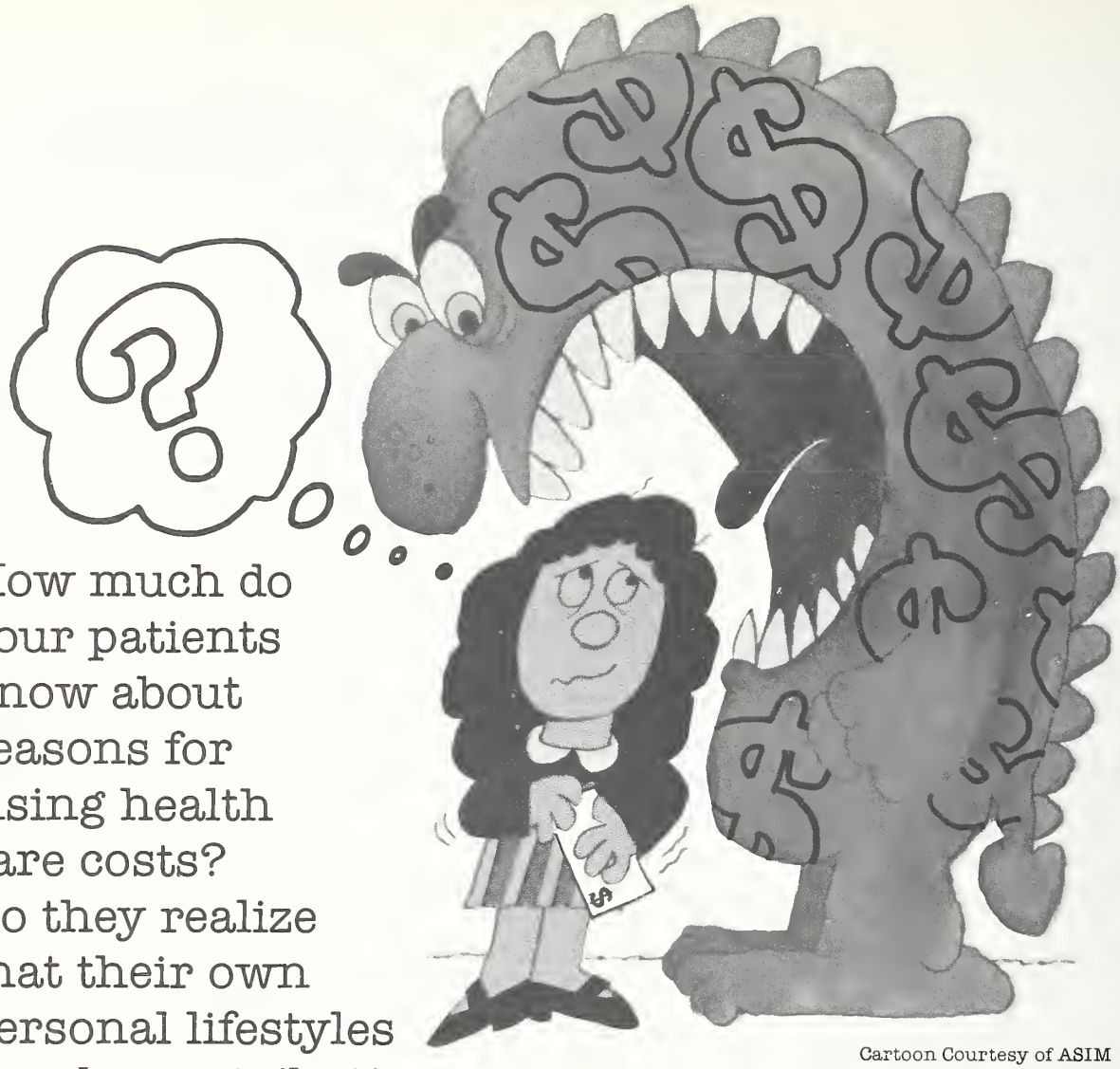
Cause of death	Rate of death (per 100,000 persons)
1900	
Influenza and pneumonia	202.2
Tuberculosis	194.4
Gastroenteritis	142.7
Diseases of the heart	137.4
Cerebral hemorrhages and vascular lesions affecting central nervous system	106.9
Chronic nephritis	81.0
All accidents	72.3
Cancer and other malignant neoplasms	64.0
Certain diseases of early infancy	62.6
Diphtheria	40.3
1975	
Diseases of the heart	338.6
Malignant neoplasms	174.4
Cerebrovascular diseases	91.1
All accidents	46.9
Influenza and pneumonia	26.3
Diabetes mellitus	16.8
Cirrhosis of the liver	15.0
Arteriosclerosis	13.7
Certain diseases of early infancy	12.5
Suicide	12.4

Source: National Center for Health Statistics.

Decline in the death rate from selected diseases following the introduction of pharmaceuticals, 1958 to 1974

Disease entity	Percent decline	Type of pharmaceutical
Poliomyelitis	100	Vaccines
Whooping cough	100	Vaccines
Hypertensive heart disease	92	Antihypertensives
Tuberculosis	75	Antibiotics
Dysentery	50	Antibiotics
Appendicitis	64	Antibiotics
Asthma	69	Corticosteroids
Meningitis	46	Antibiotics
Syphylis	95	Antibiotics
Maternal deaths	67	Antibiotics
Nephritis and nephrosis	46	Antibiotics
Infant deaths	67	Antibiotics

Source: National Center for Health Statistics.



How much do your patients know about reasons for rising health care costs? Do they realize that their own personal lifestyles may be contributing to this rise?

Cartoon Courtesy of ASIM

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Let your patients know you're concerned about rising costs and you need their help in controlling them. These colorful, informative posters are available at $4.95 per set; 2 sets for $8.00, and 3 sets for $10.00.

Send your check or money order made payable to the OSMA to: OSMA, Attention: Department of Communications, 600 S. High St., Columbus, Ohio 43215.

The Future of Pharmaceuticals

By Clement Bezold, Ph.D.

The following article has been reprinted, with permission, from "The Future of Pharmaceuticals. The Changing Environment for New Drugs," by Clement Bezold of the Institute for Alternative Futures. (John Wiley, 1981) The article has been edited to meet space requirements.

Victor Fuchs noted that drugs are the key to modern medicine. "Six dollars are spent on hospitals and physicians for every dollar spent on drugs, but without drugs, the effectiveness of hospitals and physicians would be enormously diminished." The great power of drugs has developed during the last 40 years, (and) during this age of new pharmaceutical therapies, medical care has advanced beyond mere diagnosis of certain diseases.

With drugs and vaccines, medical science is (now) able to reduce the incidence of (many) infectious diseases — and smallpox has been eradicated through an aggressive vaccination program. Many of these advances began in the 1930s and 1940s with the development of sulfa drugs and antibiotics. More recently, a variety of drugs has been used with great success to treat arthritis, high blood pressure, psychoneurotic conditions, diabetes, epilepsy, circulatory diseases, and certain bacterial infections.

Drug development begins with a decision to make the drug available for human use and ends when the first quantities are marketed. Although the research process takes place in industry laboratories, government research institutes (and) universities, the development process is performed almost exclusively by drug companies.

In the United States, the development process is regulated by the 1938 Food, Drug and Cosmetic Act. When a compound is chosen for development, initial screening in rodents and other animals follows. Specialists from numerous disciplines become involved, and developmental chemists undertake large-scale synthesis of the compound. If continued testing suggests a significant therapeutic effect, toxicity studies are initiated. Generally, the drug is administered to dogs or monkeys in the dosage form proposed for human use, and careful research is done to determine any toxic effects. If tests to this point suggest the drug is safe and effective, physician researchers begin carefully controlled testing in human volunteers. Approval of the Food and Drug Administration (FDA) to market the drug is granted only after satisfactory clinical trials and may include a requirement for postmarketing surveillance of the drug and its potential side effects.

The effectiveness of this approach to drug development is the focus of active debate. There is agreement, however, that drug companies are virtually the only entities with the extensive resources needed to develop and market a new drug.

Forecasting the future

What social benefits can be expected from drug research in the next 20 or more years? Drug forecasts can provide a context for thinking about policy options, but they cannot predict precisely which new drugs will be available. Nor can forecasts answer questions that policymakers must face regarding relative effectiveness of drug therapy compared to other forms of disease prevention and treatment.

One of the first major surveys of the pharmaceutical industry was conducted in 1968 by Dr. A. Douglas Bender for Smith Kline and French Laboratories. Thirty-five experts expressed their opinions on future developments in health care, therapy, biomedical research and medical education. A more recent survey of the future of the medical field was taken in 1976 by *Medical World News*. Both surveys indicated a number of developments that would take place by the years 1980, 1990, and 2000 (see table). Another approach to forecasting is to identify key individuals who can relate forecasts to underlying causes, or in this case, the research areas that will ultimately have the highest payoff for pharmaceutical treatment of disease.

Lewis Thomas, writing in 1977, stated that, "The major diseases of human beings have become approachable biological puzzles, ultimately solvable." It follows from this that it is now possible to begin thinking about a human society relatively free of disease. Thomas felt that the experience of the past 50 years suggests two principles about human disease. First, it is necessary to know a great deal about underlying mechanisms before one can really act effectively. Second, for every disease there is a single key mechanism that dominates all others. For example, he proposed that while dozens of separate influences, including environmental carcinogens and many sorts of viruses, launch cancer, there is a single switch at the center of things. Schizophrenia will turn out to be a neurochemical disorder in which some single central chemical event has gone wrong. Rheumatoid arthritis, coronary occlusion and stroke will all be found to have single key mechanisms. According to Thomas, many of these mechanisms may involve a common set of problems now being addressed by many researchers: How do cells and tissues become labeled for what they are, what are the forces that govern the orderly development and differentiation of tissues and organs and how do errors in the process occur?

There is disagreement in the research community over the appropriate balance between basic and applied research and the relative distribution across specialties. There is also less optimism on the part of some clinical researchers and those involved in moving drugs through the approval process. But, by and large, there is agreement on our ultimate ability to control most diseases. OSMA

"Lewis Thomas, writing in 1977 stated that, 'The major diseases of human beings have become approachable biological puzzles, ultimately solvable.' It follows from this, that it is now possible to begin thinking about a human society relatively free of disease."

FORECASTING THE FUTURE: ROLE OF DRUGS IN TOMORROW'S SOCIETY

The year 1980

- the therapeutic armamentarium of a first-term student in medical school in 1980 includes drugs for the cure or prevention of hypertension, edema, skeletal muscle spasm, autoimmune disease, fungal infections, drug dependence, thrombosis, obesity, anxiety, tension, depression, asthma, and dental caries; cell-specific therapy for certain neoplasms, a hepatitis vaccine, nonnutrient foods for obesity control, and a variety of special diets for patients with such diseases as atherosclerosis and phenylketonuria will also be available; drugs and other new methods controlling male and female fertility will be at the physician's disposal
- negligible morbidity and mortality for childhood malignancies, notably leukemia and Hodgkin's disease, as a result of new therapeutic regimens
- highly accurate enzyme and radioimmunoassay screening of persons with a high risk of cancer
- H2 blockers for routine treatment of ulcers and erosive hyperacidity
- H2 receptor-blocking agents for treating peptic ulcers are in their fourth year of clinical trial
- satisfactory clinical management of essential hypertension
- successful treatment of herpes simplex
- medical treatment of schizophrenia, depression, and other mental disorders
- effective monitoring of drug therapy
- nonaddictive analgesia for intractable pain

The year 1990

- therapeutic regimens for all pediatric cancers
- complete detectability of cancer through enzymes and radioimmunoassay
- chemotherapy or immunotherapy for gastrointestinal malignancies as well as kidney, bladder, and prostate cancers
- dramatic reduction in the incidence of sudden cardiac death and myocardial damage from severe obstructionary coronary artery disease
- vaccine to prevent diabetes
- treatment of psoriasis and melanoma
- prevention of all important viral diseases by immunization with purified antigens
- manipulation of cellular immune reactions in delayed hypersensitivity, autoimmune disease, suppression of fertility, and organ transplantation

The year 2000

- prevention of inheritable diseases
- prevention of mental illness, nephritis, degenerative vascular disease, arthritis, and, increasingly, cancer
- nontoxic and almost completely effective cancer chemotherapy
- treatment of psychiatric disorders by correction of molecular basis of pathogenesis

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The Physician-Prescriber

Promoting Appropriate Prescribing

By Joseph H. Skom, M.D.

Prescribing Requires Meticulous Care

The prescribing of any drug must be done with meticulous care, with attention given not only to the potential therapeutic benefits of the medication, but to possible side effects as well. No drug is entirely safe, and no drug is free of adverse reactions.

The medical administration of drugs is an interactive process that involves the time and frequency of administration, the form and size of dosage, the pharmacology of the agent, and the physiological and psychological make-up of the patient, including whether he is fatigued or rested, whether he has eaten or fasted, and whether he feels comfortable or uneasy. The prescriber needs to assess all of these components to arrive at a risk-benefit ratio in each individual case. What is indicated for one patient may not be suitable for another.

DEA's Practitioners Committee

If all of this is true for any drug, it is especially pertinent to the prescribing of controlled substances which have varying degrees of potential for abuse and dependence — a potential that introduces an additional element to the *risk* side of the equation. Most prescribers are now aware of the hazards of iatrogenic drug abuse, ie, abuse that is initiated or perpetuated, usually inadvertently, by the practitioner. Most professional associations represented on the DEA's Practitioners Committee have issued warnings and cautionary statements, and the Committee itself has prepared a set of general prescribing guidelines that have been endorsed by each of the member organizations.

Nevertheless, even though such pronouncements correctly warn of the dangers of misprescribing and emphasize ways to avoid pitfalls, they should not be regarded as the *last word*. Rather than end points, they are beginnings. Practical working guidelines, if you will, devolve from these sets of principles and, for the most part, are unwritten. They are not uniform or immutable, but vary from one type of practice to another and, of necessity, often change from one patient to another. This they must do because medicine is as much an art as it is a science; it cannot be practiced within rigid confines.

Patients Are Never Identical

This is not to say that prescribing cannot be consistent with the general principles that have been enunciated. It can and should be. It cannot, however, be codified, nor can it be made as precise as a recipe in a cookbook, with standardized indications, dose levels, and frequencies for the administration of each drug. Patients may be similar, but they are never identical.

Is each practitioner, then, to be left to his own interpretation of how prescribing principles are to be applied? After all, these principles have existed in one form or another for a long time and yet we are still faced with too many examples of prescribing that are not in the best interest of the patient or the public. (*Here I refer not to the blatant and willful overprescribing of drugs of abuse for profit, but primarily unintentional and uninformed acts of choosing a wrong drug, or designating too large an amount, or renewing a prescription order too many times.*)

Education Is A Key Ingredient

There is a middle ground that we can cultivate to a much greater extent than we have in the past, and that is the area of education. Education may be formal or informal. In the prescribing of controlled substances we need to rely on both kinds.

Formal education, as far as medicine is concerned, consists of medical school, residency training and what is referred to as *continuing education*. Medical schools are doing a far better job of teaching their students about substance abuse than they did 10 years

Joseph Skom, M.D., F.A.C.P., is Associate Professor of Clinical Medicine, Northwestern University Medical School and is a member of the DEA Practitioner's Working Committee.

ago, but there is still room for improvement, especially in delineating the prescriber's role in drug abuse and his own vulnerability to drug dependence. The same can be said for the postgraduate training period; additionally one could wish to increase involvement of residents on hospital drug utilization committees.

Symposia, seminars, and structured short courses on prescribing, with case examples, can be valuable for the physician in practice. An inducement for attending programs of this kind is the availability of continuing education credit hours, which are needed in a growing number of states for relicensure.

Still, those who stand to benefit the most from such information tend not to be among those who attend programs of this kind. The situation is similar to the church attendance of the *saved* rather than the *sinners.*

This is where *informal* education can be called into play.

What do I mean by this term? Simply, the relatively unstructured learning of practice-oriented information. It may take any of several forms. Let me indicate a few that I believe can provide opportunities for changing prescribing behavior for the better.

Prescribing Principles Have Special Relevance

The first is independent recognition by the individual physician that one or more of the prescribing principles have special relevance to his own practice. Let us say, for example, that the physician is reading the AMA statement, Barbiturates and Barbiturate-Like Drugs,* and that the following sentence leaps out from the page because it bears directly on what he is and is not doing: "Use barbiturates and other sedative-hypnotics for relief of severe symptoms, but avoid them for minor complaints of distress or discomfort." The conscientious physician who reads this will remember it the next time he considers prescribing sedative or hypnotic drugs, and he is likely to be guided accordingly.

Peer Guidance

Another type of informal education can take place when inappropriate prescribing by a physician is called to his attention by a partner or other colleague. Referring again to the AMA statement on barbiturates, the judicious prescriber will be careful to *"use dosages that will not lower sensory perception, responsiveness to the environment, or alertness below safe levels."* If someone sees that a colleague consistently is prescribing dosage levels that clearly exceed the limits of safety, explicit concern can be expressed. Again, if the practice has been unintentional and if the physician involved is a conscientious and responsible person, improvement will likely result.

Peer Review

Less informal but still not as structured as symposia or courses is yet another educational mechanism which can be called the peer review process. This process can be set in motion in at least three ways.

First of all, it may be initiated by a patient. Still keeping to the above-cited AMA statement, let us say that a physician fails to heed the following admonition: *Warn patients to avoid possible adverse effects because of interactions with other drugs, including alcohol.* A patient may have had a drink or two shortly before or after taking sedative medication, and the combination then produced shock or respiratory depression. The patient could justifiably complain to the grievance committee of the physician's medical society, and corrective action would ensue.

A second route to peer review is provided by the medical society itself or another professional association or group, such as a hospital drug utilization committee. *"Attempt to diagnose and treat underlying disorders before relying on drugs of this class for symptomatic relief,"* says the AMA statement on barbiturates. Continual disregard of this basic tenet of sound medical practice can and should be seriously discussed with the physician in an effort to improve the quality of patient care. *(It is important to recognize, however, that there are times when the physician is unable to readily establish a diagnosis. In such cases, it is neither immoral nor bad practice to treat symptoms.)*

A final approach to peer review can be made through the activities of drug enforcement officers. Both national and state personnel seek to assure compliance with drug abuse laws and regulations. One of their major concerns is to prevent and curtail unlawful prescribing. It is in the course of their investigations of such alleged misprescribing that they often come upon practices that may be medically questionable but not illegal. For example, a physician could be prescribing amphetamines to treat cases of long-term endogenous depression. This is not an illicit use of amphetamines under federal law, even though it is not included among the FDA-approved indications. In most instances, however, it is an unwise use and one that enforcement agents could bring to the attention of a medically-constituted body once the procedures for doing so were established by prior agreement between the medical and legal communities.

Upgrading Prescribing Preferable To Curtailing Availability

There are, then, a variety of workable methods for upgrading the prescribing practices of physicians — methods that rely on didactic information, case examples and peer persuasion for their effectiveness. The employment of such methods would seem preferable to blanket limitations on the prescriber's freedom to use certain drugs in certain ways, or to the elimination of individual drugs or whole classes of drugs from the marketplace. To restrict unduly the prescriber's range of chemotherapeutic choices for any given patient not only might not be in the best interest of either the patient or society at large, but could even jeopardize that patient's health and future well-being.

Reference:
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This article has been reprinted from Vol. 1, No. 6 issue of the DEA's Registrant Facts.

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The truth is, everyone is subject to a well-laid scheme

The UNWITTING ABUSERS

By Karen S. Edwards

"Dupe." The word tastes like a bitter pill on the tongue and is just as hard to swallow. No one likes to admit that they possess even that modicum of vulnerability and naivete which is necessary for a swindle or "con" to work — and yet, the truth is everyone is subject to a well-laid scheme.

Even physicians, as well educated and highly skilled as they are, are not immune to the professional criminal's glib tongue and preplanned tricks of the trade. In fact, because physicians possess the power to legally prescribe and dispense drugs, they are especially vulnerable, in today's society, to a select group of con artists . . . namely, the drug addicts and illegal prescription rings.

"A drug addict gets to be very good at fooling doctors," wrote a convicted addict in a 1976 issue of the AMA News. With his own account, he exhibits the great extremes to which addicts will go to fake symptoms of illnesses which are usually controlled by strong, pain-killing drugs.

Couple this information with the results of a survey recently sponsored by the Texas Medical Association's Committee on Alcoholism and Drug Abuse. The survey found that one quarter of the participating physicians admitted they were reluctant to turn down patients' demands for drugs, if the patient felt he needed them. Is it any wonder, then, that almost every day, physicians and dentists are being duped into prescribing drugs for illegal purposes?

By no means, however, is the problem limited to Texas, or to any other area of the country. Unwitting abusers can pop up anywhere. In fact, last year some even popped up right

here in Ohio.

"Last summer our office began to receive a number of calls from area pharmacists and local police about forged prescriptions," says Dan Ponstingle, Director of the Lake County Narcotics Agency, a county-funded organization which operates in the northeast corner of the state.

"As we investigated, one suspect led us to another and another. Eventually we found that an illegal prescription ring was operating within a five-county area of the state."

According to Ponstingle, suspects in this particular ring would go from physician's office to physician's office working a whole building at a time.

They would walk in as "first time" patients carrying false identification cards and complaining of pain from old Vietnam injuries, migraine headaches, back pains or pain from oral surgery. They would tell the doctor that they were from downstate or had just moved into the area and needed a new prescription.

"If the physician was hesitant to write them one, they would threaten to go to an emergency room for it," says Ponstingle.

So, often with little or no exam, these patients would procure the drugs they had come for.

"One suspect we arrested admitted that he had obtained prescriptions from 53 physicians in a 15-month period," says Ponstingle, "and when you consider that's just one suspect, you can see how prevalent the problem is."

Unfortunately, not all areas of the state (or the country, for that matter) have active enforcement agencies. Lack of funds and manpower prevent other cities and counties from cracking such prescription rings. That's why it has become important for physicians to realize that these kinds of "cons" occur, and what can be done to prevent them.

"We get calls from physicians when seedy-looking characters come into their offices and demand prescriptions. The doctors tell us that frankly they're afraid not to comply, and I think everyone can sympathize with them in these situations," says Ponstingle.

He urges physicians to maintain contact with their local police departments and to keep the police phone number handy so that when such situations arise, help can be obtained immediately.

"Receptionists should also make it clear to patients that they must have an appointment before seeing the doctor," he adds.

"It's embarrassing to be duped, but it's much worse to be aware of the situation, and do nothing."

But the "criminal element" is not always easy to recognize. "Some of these people are actually quite attractive and well groomed . . . not the kind you would expect to see in a prescription ring," says Ponstingle. Certain habits, however, sometimes make it easier to identify them. "Usually they attempt to fill prescriptions on a Wednesday, when most physicians are out of their offices. That's why it's also important for the receptionist to be alerted to these situations."

Often, too, these people will insist on paying for everything by cash. Rarely do they ever use insurance.

Ponstingle stresses, however, that because it's difficult — and dangerous — to try to single out who is faking symptoms and who is not, the best thing a physician can do to help eliminate the problem is to simply tighten up office procedures. "In many of those cases where a physician has been duped, it has been due to administrative sloppiness and inattention," says Ponstingle.

Prescription blanks, he says, are too often available and should be kept under tighter control — either in the physician's jacket where they're accessible to him, but generally unavailable — or better yet, under lock and key.

He also asks that doctors screen first-time patients more closely — especially if they request a drug which is commonly abused, or complain of symptoms which require such drugs.

"We're not trying to tell physicians how to run their practices," Ponstingle adds, "but unless they are more careful and tighten up their offices so that prescriptions are not as easy to come by, they run the risk of being duped."

Currently, most police departments and enforcement agencies do not assume any intentional criminal liability on the part of physicians — but if enough instances occur, it can become a sensitive problem.

"In some cases we found that a number of addicts were patronizing certain physicians — and getting what they wanted — but it's difficult to tell when a physician is being duped and when there's intentional liability. It's a very touchy problem, and a tough case to prove."

Like most local narcotic agencies, Ponstingle says, his agency works closely with the Ohio Board of Pharmacy and to a lesser extent, with the Ohio State Medical Board.

"The drug problem is a circuitous one. A doctor is duped into prescribing a drug, the drug goes out on the street and becomes an enforcement problem and maybe even a medical problem — everybody loses," Ponstingle says.

"And the problem is more widespread than most doctors think. It doesn't just happen to a small minority of bad doctors. It can happen to any prescriber. Let's face it — we're all taken for a ride from time to time."

"It 's embarrassing to be duped," he adds, "but it's much worse to be aware of the situation and do nothing."

"If I could offer just one piece of advice, I would urge the medical community at large to tighten up their procedures and limit as much as possible their dispensation of drugs," Ponstingle concludes.

In other words, to modify the legal world's advice to consumers just a bit, "Let the prescriber beware!" OSMA

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My Brother's Keeper

By Karen S. Edwards

Impaired professionals are no longer the medical profession's "closet skeletons." Today, they are recognized and being helped for what they are — sick physicians who have been disabled by senility, psychiatric disorders, alcoholism, and in some cases, drug abuse. The lessons they learn are hard, but what they in turn can teach their colleagues is invaluable.

Whispers grow behind cupped hands and sidelong glances accompany the faltering smiles.

"The doctor isn't feeling well today," says the loyal staff, the patient family — but they bite back the dismal prognosis for tomorrow.

No one is willing to admit, at least not yet, that "the doctor" has become hopelessly dependent on drugs — the kick-in-the-pants amphetamines that get him going in the morning, and the barbiturates that put him to sleep at night.

"He's a professional, an educated man — he knows what he's doing," they assure each other and themselves — and the doctor slips into their logic as if it were a comfortable pair of old slippers.

"I'm a professional, for heaven's sake, I'm no addict."

According to Perry R. Ayers, M.D., a Columbus physician who gave the keynote address at this year's Mid-Eastern Regional Conference on the Impaired Professional, such an attitude is not an uncommon one for these physicians to take.

"The impaired professional develops denial to a fine art," he says. "They believe there's a professional immunity to such problems as alcoholism and drug abuse, and they deny, not only to others, but to themselves, that they could possibly be heading for trouble."

Those who do admit that they "drink a little more than they should," or are "relying a bit too much on drugs," are convinced that they can handle the problem by themselves.

"Of course, they can't," Dr. Ayres says, "and it's important we, as their colleagues, intervene in this impairment process as soon as possible."

Dr. Ayres believes that the entire medical profession is a brotherhood, "and I am my brother's keeper," he says.

"We need to be sincerely concerned, not only for the patients who may be affected by the impairment, but for the colleague and his family as well."

"It is a whale of a lot easier to gather our forces against the incompetent, the charlatan, the medical bastard," agrees Donald M. Keith, President of the Washington State Medical Association who spoke at last year's AMA Impaired Physician Conference. "Against the good guys, it is hard. But you were elected to medical leadership for your ability to take on the hard ones — to make the gut-wrenching decisions and carry through."

"Carrying through," according to most experts in the field, means seeing to it that the impaired colleague gets professional help.

"The doctor who comes to you and asks for help is consulting the wrong person for the wrong reasons. The greatest kindness you can offer a sick friend is to advise him to seek professional help, preferably in an institutional setting," says Dr. Ayres.

LeClair Bissell, M.D., directs an alcoholism unit in Newport, Rhode Island, and is nationally known for her work with impaired professionals. She also spoke at the recent Mid-Eastern Regional Conference on the Impaired Professional.

"We always tend to diagnose chemical dependency in our colleagues too late. We rationalize for each other. But I agree with Dr. Ayres," she said, "we have to move in early before the damage is done."

Dr. Bissell also agrees that institutional settings are best for

rehabilitation — though she recommends against putting the physician in the "family" hospital where he works.

"At least in a different setting he won't know the people who are gossiping about him," she quips.

An unfamiliar setting also forces the physician to operate within a lay group, which Dr. Bissell believes is important.

"I think we're too special, too clannish," she says.

Too often the physicians entering the treatment center where she works expect the best treatment in the shortest length of time, and she admits that she sometimes has to make a concerted effort to see that those who do enter the facility are treated like everyone else.

"We're not different from other folk. We're human beings, we have problems," she says.

But what makes certain physicians turn to chemical dependencies when confronted by stress?

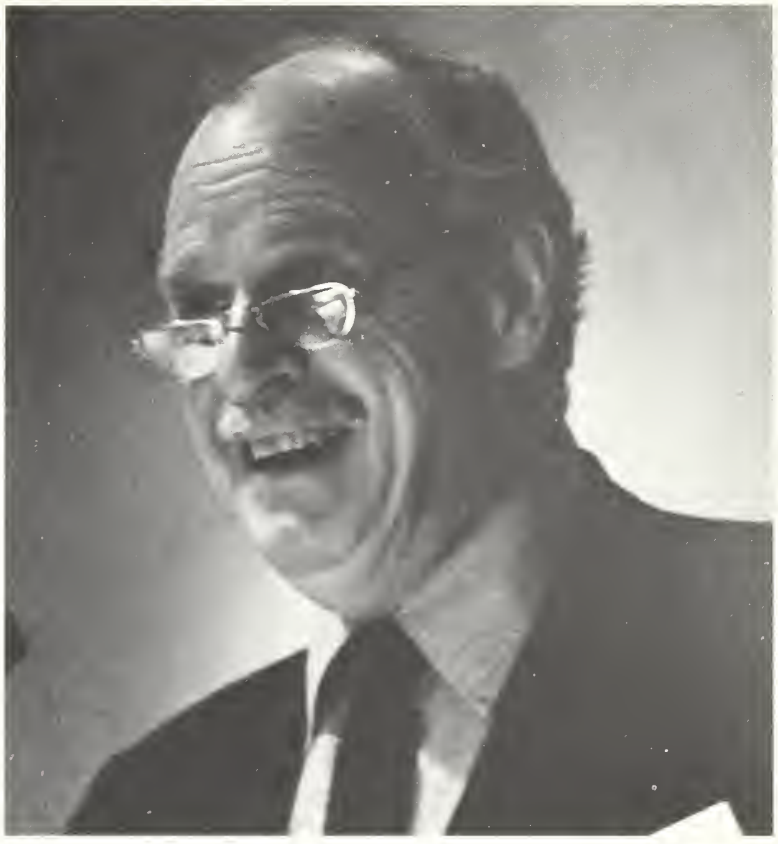
The "physician-at-risk," as Dr. Ayres describes him, has several characteristics.

"From the time they enter medical school they see themselves as different. They may have many friends, but no one really knows them because they're careful to shut themselves off. They isolate themselves emotionally. They're givers, but they can't receive," he says.

This impaired self-perception grows until they see themselves as having value only as physicians. Life and death depend on what they know, so they must know everything. They throw themselves into their work, and soon nothing becomes more important than the practice. Families have to learn to adjust, and they usually do so by going their separate ways. If the physician indulges in play, it's usually intellectual hobbies.

For a while, his status and his work buffer him from life's stresses — but there comes a day when the stresses are too much, and burying himself in his work doesn't help. Because he's isolated himself emotionally from family and friends, he has no one to turn to for support.

So, he begins to take a drink or a



Perry Ayres, M.D.

LeClair Bissell, M.D.



pill to help relax — and all the time he denies to himself that he has a problem.

"The physician may run the system, but he is also run by it," says Douglas A. Sargent, M.D., of Grosse Point Farms, Michigan, another speaker at the Mid-Eastern Regional Conference on the Impaired Physician.

Dr. Sargent also believes that the competitive, selective nature of today's health-care system is breeding a high degree of tolerance in its physicians.

"They ignore their problems as much as possible for as long as possible. Those who can and do function normally are weeded out during the rigors of medical school, and consequently," he says, "the highest performers in the medical system are usually the most handicapped emotionally."

If and when the professional does seek help, he is faced with yet another basic conflict — having to assume the role as patient. It's a difficult role for most physicians to play, but, as Dr. Bissell cautions, "the impaired professional had better know what hat he's wearing when he comes in for treatment," because unless he or she is willing to submit to medical authority in a patient role, the recovery process will be a long one."

"There are four management roles in the impaired professional's recovery program," says Dr. Ayres, "the patient, the authority, the colleague and the therapist. The delineation of these roles must be clearly understood by each participant."

Just as the impaired physician must learn to function as a patient, however, Dr. Ayres emphasizes that it's important for the colleague to learn to play his role in the recovery process.

"The concerned colleague must provide support, help, and empathy to the patient, not only during rehabilitation, but during the patient's reentry into the medical profession," says Dr. Ayres.

There is, he concludes, a very real need for the impaired physician to return to the fold, the brotherhood, and to belong again. To become, as the rest of the profession must become, his brother's keeper.



A PEP Talk

In 1975, the Ohio State Medical Association (OSMA) Committee on Mental Health decided to come to grips with the problem of the impaired physician.

The result was the "Physician Effectiveness Program" (PEP), a program ratified by the OSMA House of Delegates in 1977, and specifically designed to recognize and help those physicians who have become impaired by psychiatric illness; senility, alcohol, drug abuse, and other disabling factors.

PEP functions on the positive principle that such impairments are treatable, and that rehabilitation is possible. Persuasion is used before coercion in every case, and anonymity for the impaired professional is assured. The program does, however, recognize its legal and moral obligation to inform the State Licensing Board of the disability if a sick physician fails to comply.

The impaired professional who wishes guidance need only call the OSMA offices (228-6971), leave name, address and phone number, and indicate his or her desire for help. The appropriate staff member will contact a District Liaison Physician (DLP) who will in turn, contact the sick physician to discuss the problem, and help him arrange for appropriate treatment. When the impaired professional enters treatment, OSMA's involvement ends.

The PEP program includes channels for peer initiative, so that a concerned colleague might recognize and involve in the program a fellow physician who appears to be in need of help. The program assures anonymity for the caller, and provides careful checks before the impaired physician is approached. The same procedure is then followed as if the sick physician had made the call himself. Only if the physician refuses to take part in the program after several contacts have been made, will the committee bring the matter to the attention of the Ohio State Medical Board.

The program's principal purpose, however, lies in its attempt to remove the stigma of the "impaired professional"; to induce the sick physician to seek treatment before family, career, and lives have been destroyed; and to induce the medical profession at large to become "my brother's keeper." — KSE

Some Prescribing Problems

By George D. Clouse, M.D.

What causes "overmedication" in patients? Sometimes it can be the very patients themselves

"Medicamentosis" is a condition I use to describe people who are "too full of medicine." All physicians know of these cases, but we need to be reminded, from time to time, of the various categories, and the problems involved in each case. For example, there are:

The Self-dosers

This category includes suicidal overdosers, accidental poisonings and, of course, those who smoke, sniff, ingest and/or inject their way through a day. This group comprises a class all by itself.

George D. Clouse, M.D., Columbus, is a family practitioner. He currently serves on the Editorial Board of the Bulletin, *the monthly publication of the Academy of Medicine of Columbus and Franklin County.*

The Nursing Home Set

These patients have been on prescriptions of one kind or another for a number of years. It's interesting that some nursing homes are beginning to recognize symptoms of "medicamentosis" in their patients and have started to put them on "drug holidays." Usually for the period of a weekend, these patients are given nothing stronger than Milk of Magnesia for their aches and pains. Although there was some skepticism at first as to whether or not these "holidays" would work (many thought that the patients would fall apart without their crucial daily dose), the patients did surprisingly well — and some actually showed improvement. This was probably due to the leveling of drug concentration in the patient — which has a tendency to build up in those, such as the elderly, who have poor renal excretion.

The Tag-ons

This over-medicated group consists of patients with complicated problems who have been hospitalized for a long time — and who undergo several medical consultations during their stay. Each consultant feels that some new medication should be added, so — many times without checking — the prescription is simply "tagged on" to an existing list of drugs which the patient is already receiving. Few physicians will take the time to sift through the thick chart to see exactly what drugs the patient is getting — and why.

Fortunately, hospitals are becoming aware of the problem, and some even have a rule that certain medications will be automatically discontinued unless a new order is written.

The Tranquilized

Another group of heavily medicated

patients are those mentally ill in institutions. These patients are given phenomenally high doses of major tranquilizers — which may make them easier for the staff to control — but which, unfortunately, render them as personable as prefrontal lobotomy patients. It's worth speculating whether or not some modality, other than massive medication, might be just as effective — if not more so — in handling these patients.

The Loyalists

This group usually consists of ambulatory patients with complex illnesses. Physicians have come and gone in their lives, leaving behind a multitude of prescriptions which the patients, out of loyalty and habit continue to take even though the medication was prescribed years ago. These patients are afraid to give up their medications and eventually must be weaned from them.

The Paradoxes

These are the people who seem to delight in reporting paradoxical results. They get a headache from taking aspirin; heartburn from sodium bicarbonate or antacid; allergic reactions from antihistamines; and even angina attacks from taking nitroglycerin. Their motives and chemistry are baffling.

By-the-book Prescribers

Some patients are prescribed the dosage suggested in the Physicians' Desk Reference (PDR). Many pharmaceutical companies often recommend fairly large maintenance doses — but many of these exotic drugs, in the recommended doses, produce some bizarre side effects. Of course, physicians then add more drugs to combat the side effects, and these drugs, in turn, produce their own baffling array of side effects. For example, some patients will experience diarrhea, while others under the same medication will be constipated; some will have anxiety, others will be depressed; some will have tachycardia, others bradycardia — and all because people are complex creatures with unique physiologic actions and chemistry.

The Poor Communicators

These patients deliberately do not communicate well with their physicians. I knew a man who was asked by his cardiologist how many cigarettes he smoked a day, and he answered "three." Later, his wife told me "three" meant "three packs." The cardiologist prescribed a vasodilator for the man — though, if the whole truth had been known, the cardiologist might have simply stressed "no smoking."

Then, there was the man who claimed his back had been strained at work. Later his wife dropped the remark that his back had been fine — until he decided to spade a rather sizeable back garden. In the meantime he was loaded with muscle relaxants and analgesics. Again, if the truth had been known, rest, physical therapy, or perhaps even a hot water bottle would have done the job as well.

The Hoarders

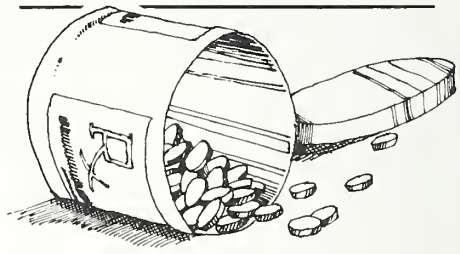


These are the people who will keep the last third of a prescription, then, at the slightest twinge in their health, they rush to the bathroom and quickly down a dose from the bottle. Some will even go one step further by getting a new prescription from their doctor, then take it in combination with the one they've been hoarding in their medicine chest.

The Deluded

Then, there are the deluded kids — from the sixth grade up — who search out their parents' private stashes of tranquilizers and other drugs. They take unbelievable combinations or amounts, which they usually wash down with a couple of beers.

The "If-one-pill-does-good-think-what-two-will-do" Group



Some people have always felt if one pill does good — two or more ought to do better. In addition to being bad health risks — these people seldom make good cooks.

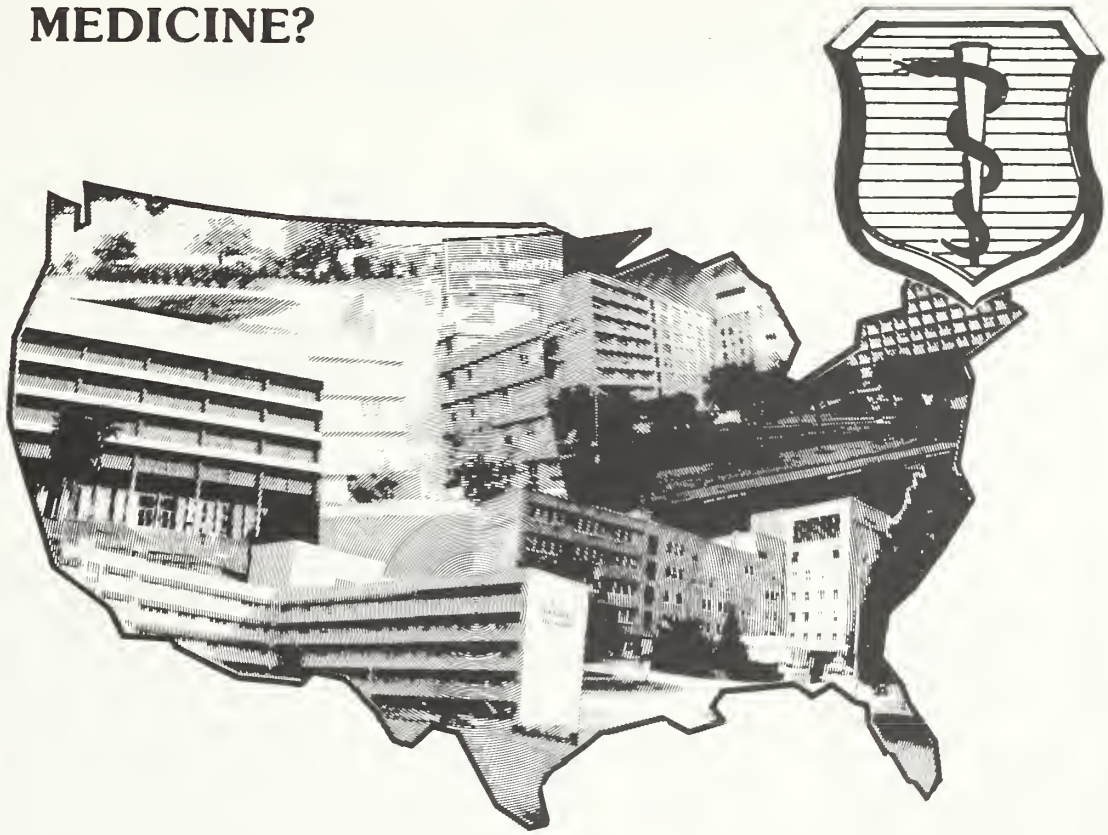
The Pseudo-pharmacists

These are the patients who, for one reason or another, are seeing several doctors at the same time — and meanwhile acquiring a stockpile of drugs — usually those which are classified or easily addicting. These patients then proceed to pop one at their own whim, or for every need they can imagine.

As conscientious writers of prescriptions, one of our goals is to avoid an over-medicated society. To accomplish this, we must take into account the effects of long-term medication; idiosyncratic reactions; pregnancy; lactating mothers; age differences; and, of course, genetic or carcinogenic possibilities — as well as the adverse reactions and side effects of the various drugs.

But if you're thinking the only safe medications to prescribe are placebos — there is our last group, "The Overreactors" — who, as we all know, can even react to these. OSMA

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Patient Package Inserts:

Instruction or Confusion in the Marketplace?

By Robert S. Young, M.D.

It is no news that Secretary of Health and Human Services, Richard Schweiker, has stayed implementation of the Food and Drug Administration's (FDA) final rule on patient package inserts (PPIs). The requirement that these inserts accompany certain drugs will be "delayed indefinitely" to give the FDA and Office of Management and Budget (OMB) an opportunity to re-examine the project's cost effectiveness.

What is a patient package insert? "Patient labeling" (commonly called a PPI), is drug information which, according to FDA regulations, would be prepared by a pharmaceutical manufacturer and distributed with the product. This labeling would be written in nontechnical language, would not be promotional in tone or content, and would be based primarily on the physician labeling for the product. The labeling would contain a summary of information about the product; detailed information identifying the product and the person responsible for the labeling; the proper uses of the product; circumstances under which it should not be used; serious adverse reactions; precautions the patient should take when using the product; information about side effects and other information about the proper uses of prescription drug products in general.

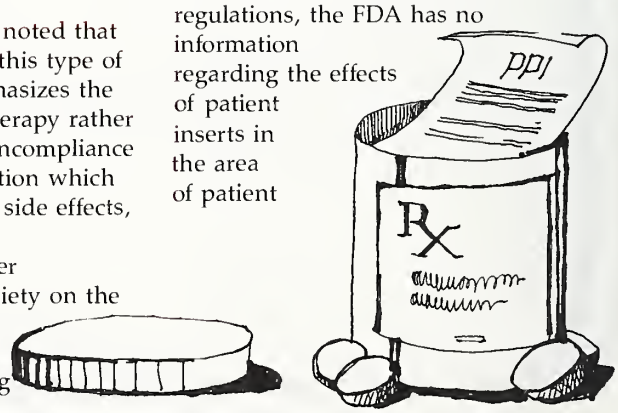
The FDA has stated that consumers will benefit from this program by being more informed about their medications, and that fewer adverse reactions and illnesses caused by improper drug usage will result.

". . . there is no national outcry from the general public or the health care delivery system for the proposed program."

However, it also should be noted that if consumers are provided this type of information — which emphasizes the negative aspects of drug therapy rather than benefits — patient noncompliance may also increase. Information which details numerous potential side effects, adverse reactions, and contraindications will trigger questions, doubts, and anxiety on the part of the patient. Who will answer these questions — the prescribing physician, who is the only one legally capable of making a change in the therapy, the dispensing pharmacist, who can only try to calm and reassure the patient and consult with the physician — or will the patient decide against completing the prescribed therapy, a potentially unhealthy and dangerous course of action?

During the "comment period" on the proposed regulations, an overwhelming majority of statements objected to the program for the following reasons:

1. No real evidence or studies exist to clearly show what type of information needs to be conveyed to consumers, or how the patient would utilize this information in using the drug properly.
2. No solid data exists to indicate that the perceived benefits of the proposed program justify the substantial costs that are inherent in the regulations. Notwithstanding the massive costs that the industry will bear in order to comply with the regulations, the FDA has no information regarding the effects of patient inserts in the area of patient



Robert S. Young, M.D., an OSMA member, is a clinical associate professor in Family Medicine at Ohio State University's College of Medicine and represented the American Academy of Family Physicians on the FDA committee which investigated the PPI concept. Dr. Young is also the Consulting Medical Editor for Synergy.

". . . a voluntary program will be more acceptable to health professionals and patients, much less expensive to implement and . . . provide greater benefits."

noncompliance nor in the short-term and long-term effect of patient package inserts, relative to a consumer's trust and confidence with the physician, the pharmacist, and in the prescribed therapy.

3. Other than support for the proposed program from a number of consumer organizations, and a few agency studies that indicate that consumers would like more information about prescription drugs, there is no national outcry from the general public or the health care delivery system for the proposed program.

The rules, which were to be implemented, stated generally that PPIs were to be provided by dispensers, including physicians, except as follows:

1. *The physician interdict* — A physician prescribing a drug may direct (in handwriting on the prescription or orally to a pharmacist) that the dispenser withhold the PPI. In this manner it can be withheld unless the patient specifically requests it. (Dispensing physicians are encouraged to provide the PPI, but need not do so unless the patient specifically requests it.)

2. *The emergency treatment exemption* — A PPI need not be given to patients who receive a drug in the course of emergency treatment (in or out of an institutional setting).

3. *The health care institution options* — Health care institutions are required to devise a system to make PPI information available to patients on request.

4. PPIs need only be provided for the initial dispensing of the drug, not for refills. The PPI will be provided to dispensers by each manufacturer and the PPI text will be included in the package insert (and in the **Physicians Desk Reference**).

Published with the final rule were the FDA "guideline" PPIs for the ten drugs and drug classes for which patient labeling (PPIs) will be required during the "initial program." They are ampicillins, benzodiazepines, cimetidine, clofibrate, digoxin, methoxsalen, propoxyphene, phenytoin, thiazides, and warfarin. A three-year evaluation will take place before PPIs are extended to include other drugs.

Witness, however, the difficulty of the "simple directions" to open a safety cap on one of today's modern prescription bottles. I have to get one of my grandchildren to open these bottles for me. I believe that government specifications will not contribute to patient understanding of drug therapy. My pharmacist at home calls the PPI the "bed sheet" approach. It is supposed to cover everything and it cannot possibly do so.

The move to stay implementation is a wise one.

In reviewing samples of the various types of patient labeling currently available or being developed, I believe patient labeling is similar to that developed by United States Pharmacopeia which provides a favorable alternative to a costly government **mandated** program.

It is my view that a voluntary program will be more acceptable to health professionals and patients, much less expensive to implement, and will provide greater benefits than the proposed government plan.

The FDA and other interested parties should investigate further the alternatives to the patient labeling proposal. It is my firm conviction that a nongovernment program, which could be an integral part of a larger patient education program, will be more beneficial to all concerned and will be worth the additional consideration.

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Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
1089G010

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Table of Commonly

Class	Trade Name* (or Source)	Street Names
Narcotic analgesics		
morphine	morphine sulfate	dope, M, Miss Emma, morpho, white stuff
heroin	none	H, hard stuff, horse, junk, skag, smack
hydromorphone	Dilaudid	lords
oxymorphone	Numorphan	blues
meperidine	Demerol	
methadone hydrochloride	Dolophine	dollys, amidone
pentazocine	Talwin	
tincture of opium	paregoric	PG, licorice
cough preparations with codeine	elixir Terpin Hydrate	schoolboy, blue velvet
	Robitussin A-C	Robby
hydrocodone	Hycodan	
oxycodone	Percodan	
Nonnarcotic analgesics		
propoxyphene	Darvon	
Barbiturates		barbs, candy, dolls, goofers, peanuts, sleeping pill
amobarbital	Amytal	blue angels, bluebirds, blue devils, blues, lilly
pentobarbital	Nembutal	nebbies, yellow bullets, yellow dolls
secobarbital	Seconal	pink lady, red devils, reds, seccy, pinks
phenobarbital	Luminal	phennies, purple hearts
amobarbital/secobarbital	Tuinal	Christmas trees, double trouble, rainbows, tooies
Other Sedative Hypnotics		
chloral hydrate	Noctec	
ethchlorvynol	Placidyl	
flurazepam	Dalmane	
glutethimide	Doriden	CIBA's
methaqualone	Quaalude	sopors
methyprylon	Noludar	
paraldehyde	Paral	
scopolamine	Sominex	truth serum
Muscle relaxants		
meprobamate	Miltown	
Anxiolytics		
chlordiazepoxide	Librium	
diazepam	Valium	
oxazepam	Serax	
chlorprothixene	Taractan	

(Reprinted with permission from "A Psychiatric Glossary," published by the American Psychiatric Association)

Abused Drugs

Central nervous system stimulants		
d, dl amphetamine	Biphetamine	black beauties
amphetamine sulfate	Benzedrine	A's, beans, bennies, cartwheels, crossroads, jelly beans, hearts, peaches, whites
amphetamine sulfate/amobarbital	Dexamyl	greenies
dextroamphetamine sulfate	Dexedrine	brownies, Christmas trees, dexies, hearts, wakeups
methamphetamine hydrochloride	Methedrine	bombit, crank, crystal, meth, speed methylphenidate
hydrochloride	Ritalin	
cocaine	cocaine	bernies, big C, coke, flake, happy dust, ice, snow
Drugs with hallucinogenic properties		
d lysergic acid diethylamide	synthetic derivative (ergot fungus)	acid, pink wedges, sandos, sugar cubes
psilocin/psilocybin	mushroom (psilocybe mexicana)	business man's acid, magic, mushroom
dimethyltryptamine (DMT)	synthetic	DMT, DET, DPT
morning glory seeds	bindweed (rivea corymbosa)	flower power, heavenly blue, pearly gates
mescaline	peyote cactus	barf tea, big chief, buttons, cactus, mesc
methyldimethoxy-amphetamine (DOM)	synthetic (derivative)	STP
myristicin	nutmeg	MMDA
muscarine	mushroom (amanita muscaria)	fly
phencyclidine	Sernyl	angel dust, dust, PCP, peace pills
Tetrahydrocannabinois		
marijuana	cannabis sativa (leaves, flowers)	grass, hay, joints, Mary Jane, pot, reefer, rope, smoke, tea, weed, Acapulco gold, Panama red
hashish	cannabis sativa, resin	
Volatile Solvents and Gases		
benzine	gasoline	
toluol	glue vapor	
carbon tetrachloride	cleaning fluid	
naphtha	cleaning fluid	scrubwoman's kick
amyl nitrite	anyl nitrite	amys, pears, snapper, poppers
nitrous oxide	nitrous oxide	laughing gas, nitrous

***Many of these drugs are sold under a variety of trade names; only a single popular example is used for each.**

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The Equalizers

As the previous section has illustrated, when the human factor (the catalyst) is mixed with drugs (the basic element), a positive or negative reaction occurs. If the reaction is positive, there is no problem, but if the reaction is negative, then a state enforcement agency may have to step in to equalize the situation.

- The Ohio State Medical Board
- The Ohio Board of Pharmacy
- Guidelines for Prescribers of Controlled Substances

The Ohio State Medical Board

By Rebecca J. Doll

Often it starts out as a simple case of keeping up with the Joneses. The long, arduous years of medical school are behind him now. His practice is off and running. It's time to enjoy some of the things he and his family have been dreaming about — vacations, homes, good schools for the kids, and some of the luxuries that others were enjoying while he was trying to make ends meet on his meager resident's salary.

But as the years slip by, the bills keep coming in. Medical school debts need to be repaid, malpractice insurance rates skyrocket, personnel salaries struggle to keep pace with double digit inflation, the family continues to purchase the luxuries and suddenly, the pressure to "keep up" comes crashing down around his head.

"And the next thing you know," says Evelyn Cover, D.O., current president of the Ohio State Medical Board, "he's taking a drug here and there to sleep on, to feel better or to keep going, and suddenly he can't get through the day without them. He's addicted and he's in trouble."

And, quite often, that's where the State Medical Board steps in. Of the many cases that come before the Board each year, about one third are related in some way to drugs.

"Usually it's one of two things,"



"Often I hear . . . Why don't you lock him up? Well, you just can't do it that way. We have due process of law in this country, and you have to go by what the law says."

As president of the Ohio State Medical Board, Evelyn Cover, D.O., hears many cases involving drug abuse.

says Dr. Cover. "The practitioner is overprescribing drugs or he is prescribing them for himself or his family. Either way, it spells trouble for him."

Trouble from the Board often begins for a practitioner in the form of an investigation of a complaint.

"When we get a complaint, we send our investigators to determine if the complaint has merit," says Dr. Cover.

To determine the merit of a complaint, investigators use many methods, including undercover visits to the practitioner's office, consultations with local pharmacists, law enforcement officials, or patients. If investigators find there is something questionable going on, the practitioner will be called to appear before the Board at an informal hearing.

According to Dr. Cover, the informal hearing is an extremely valuable step.

"It lets the doctor know two things. One, that you know who he is, and two, that you're watching him. He knows the Board doesn't think his practices are what they ought to be and often, that ends it right there. Many, knowing they're caught, often will voluntarily surrender their licenses and Drug Enforcement Agency numbers and agree to accept rehabilitative help from us."

If an informal hearing fails, a formal investigation ensues. The Board will draft a citation letter to the practitioner listing the alleged complaints. Upon receiving the letter, the practitioner has 30 days to request a formal hearing before a member of the Board.

The hearing officer listens to all the evidence, draws up recommendations and forwards them to the practitioner who then has ten days to file any objections he may have. At that point, the entire Board reviews the hearing officer's recommendations and any objections filed by the practitioner.

If the Broad decides to pursue disciplinary action, the practitioner has another 15 days to appeal. If an appeal is made, the Board in turn has 30 days to file a review of the matter with the Court of Common Pleas. From there the case may go to the Court of Appeals and the Ohio or U.S. Supreme Court.

The process, says Dr. Cover, is necessary to protect the rights of all parties involved.

"Often I hear someone say, there's this doctor and he's overprescribing and he's got all the kids in town going in there for uppers and downers. Why don't you lock him up? Well, you just can't do it that way. We have due process of law in this country and you have to go by what the law says. You have to do informal and formal hearings. You have to have transcripts. Sure it's a tough process, but it often shocks a practitioner into realizing he can and just may lose his license for a year or even indefinitely."

Although she believes a primary reason for drug problems among physicians is due to living beyond their means, Dr. Cover cites alcohol as a second cause.

"They start out drinking a little and the next thing you know they're drinking more and more, possibly to ease tensions and pressures. Then the pills start coming. They seem to go hand in hand. We see it all the time at the Board. It's like a pattern."

Pressure, Dr. Cover maintains, comes from trying to keep up, not from the patient load in the medical practice.

"Pressures from patient load aren't what cause problems, although many will tell you that. But it's a myth. We have too many doctors. It's the pressure of trying to maintain an image that he thinks he must maintain in society and it's absurd."

Another popular myth, according to Dr. Cover, is the claim by some older physicians that they are being tricked into prescribing drugs to pushers and others.

"That is the biggest myth of all," she emphasizes. "I can't stress that enough. In the eight years I've been on the Board I haven't seen one example of that. Not that there haven't been claims made to that effect. But in my opinion, those physicians are in it for the money, plain and simple."

The Board, says Dr. Cover, is a lot tougher than it used to be, especially with drug problems.

"There cannot be leniency with practitioners who deserve to be slapped on the wrist," she says."Problems like this are like a boil. You can't nick it, you have to lance it."

By taking such an approach, Dr. Cover believes there will be a decrease in the number of disciplinary cases due to drugs.

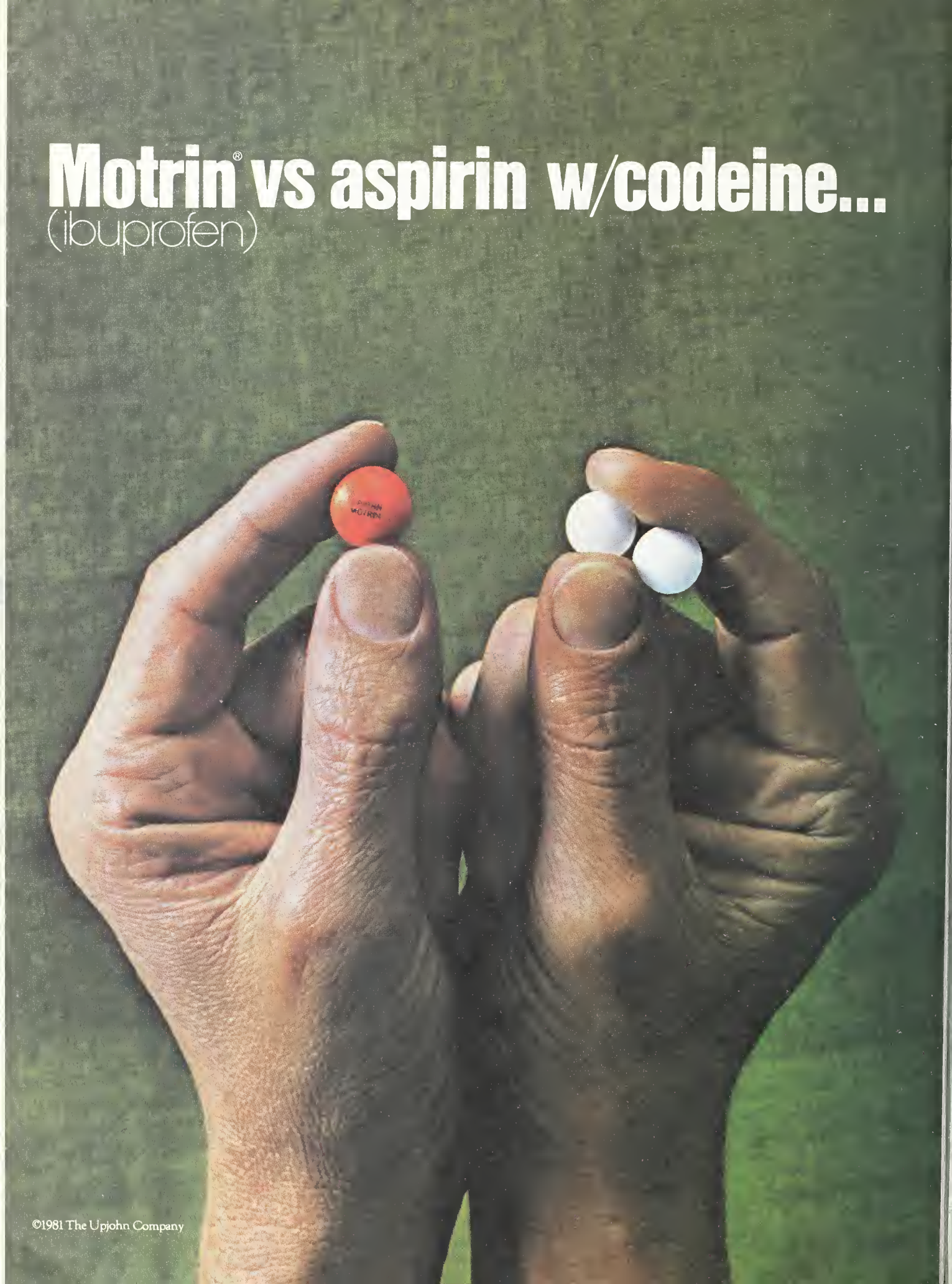
"I think we've taken a giant step in the past couple of years to convince doctors that we are looking for these abuses and are watching for the ones who overprescribe or prescribe for themselves. We're also keeping a sharp eye out for those practitioners who sell prescriptions. I don't think there is a big problem with that, but we are watching."

"Pressures from patient load aren't what cause problems . . . It's the pressure of trying to maintain an image that he thinks he must maintain in society, and it's absurd."

Watching and disciplining however, are not the only responsibilities of the Board. Its biggest and probably most difficult task is to help rehabilitate practitioners. Although general public awareness of drug abuse and law enforcement agency efforts to crack down have helped, Dr. Cover believes efforts by hospital staffs and county and state medical societies to monitor and help their own people will also contribute toward a decrease in

continued on page 308

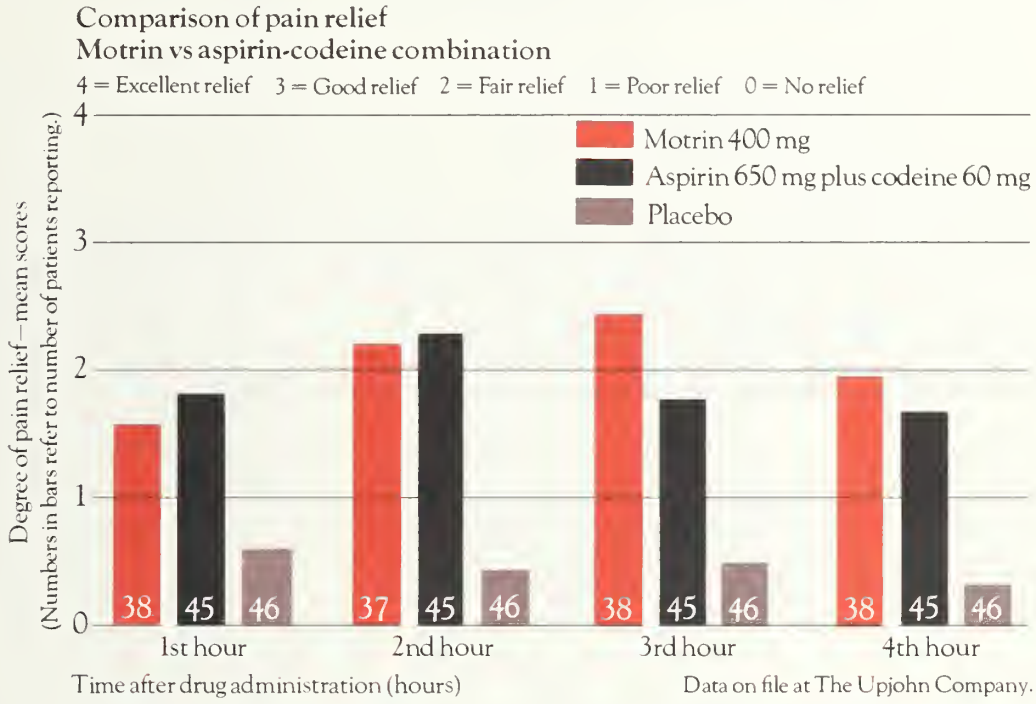
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(ibuprofen)



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A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.



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Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

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The Ohio State Medical Board (continued)

disciplinary cases due to drugs.

"That's where our greatest help is coming from today. Programs such as the OSMA's Physician Effectiveness Program have been extremely helpful in getting practitioners the rehabilitation they desperately need," she says.

Rehabilitation can consist of anything from psychiatric treatment to required attendance at Alcoholics Anonymous meetings. After prescribing a program of rehabilitation, the Board receives periodic reports on the practitioner's progress.

"When a practitioner comes before you, you really feel for them because so many of them have lost it all — first their practice goes, then they lose the respect of their colleagues, the hospital staff, their office staff, the nurses. Then the family goes, they lose all their material things — they've lost it all and it's a pathetic sight. But sometimes I think they have to lose it all before they'll come to us for rehabilitation. And the thing I'm most proud of is that we are able, in almost every case, to help."

Dr. Cover relates a case which came before the Board several months ago.

"We had a man who had lost it all — his position, his family, his material wealth — everything. Eventually, he came to us. We developed a program of rehabilitation for him and recently he appeared before the Board for a periodic review. He stood before us and it was obvious that he was well on the road to recovery. He looked at us and said, 'Here is an example to you. Never give up on anyone.' It's a proud moment, knowing you were able to help one of your own."

Rebecca J. Doll is Associate Executive Director of the Ohio State Medical Association and Director of its Department of Communications.

The Ohio Board of Pharmacy

Carol W. Mullinax

"Ask for help." That's the advice the Director of the Ohio Board of Pharmacy has for physicians with prescription drug questions.

In this day and age it is hard to imagine a doctor who hasn't encountered at least some problems with prescription drugs — patients who try to deceive them into prescribing drugs unwisely, difficulty in following proper procedures in prescribing certain drugs or, in some instances, trouble themselves either with using or selling drugs illegally.

Frank Wickham, Director of the Ohio Board of Pharmacy, is well acquainted with all of these problems — and more. His agency is responsible for policing the legal drug business in Ohio. This involves working closely with the State Medical Board and the Drug Enforcement Agency.

The powers of the three agencies tend to overlap but generally, Wickham says, their job is analogous to a sort of highway patrol. He says if you picture the flow of prescription drugs as a road leading from the drug manufacturer to the patient, the Board of Pharmacy's job is to guarantee safe conduct from start to finish. This involves stopping anyone who tries to intercept or siphon off the drugs before they reach their destination — including drug salesmen, pharmacists, physicians, nurses, and patients.

It is a difficult job that has gotten more difficult in recent years. When the Board of Pharmacy was founded nearly 100 years ago, its duties centered primarily around controlling poisonous substances. One of its first cases involved an enterprising medical student who decided to weed out the competition by adding strychnine to their coffee at a local cafe.

Through the years the drugs have gotten much more sophisticated and so have the people who abuse them. Now the typical case may involve a family-operated drug ring which continuously visits a large group of doctors to build up a supply of drugs or a physician who is intimidated into supplying an abuser with drugs.

The Board of Pharmacy logs about 8,000 calls a year from the general public, police, and health care professionals who have questions about drugs or would like to report suspected misuse. Some inquiries — such as one by a patient who complained about being charged by a physician for dispensing a drug sample — can be handled easily. It is not illegal so there is nothing the board can do. But many complaints require a more extensive investigation. For example, a pharmacist may report that a local physician is prescribing a large number of controlled substances. While there may be a logical reason for this — the physician may see mostly Workers' Compensation patients and prescribe a large number of pain killers — in some cases, either by design or by mistake, the physician could be involved in illegal practices.

When the agency receives a complaint such as this, it usually checks with the medical board and local law enforcement agencies to see if they have had similar complaints. If it is determined that there may be a case, a case number is assigned and it is forwarded to an investigator in the area. The Board of Pharmacy employs 20 people, ten of whom are investigators. These investigators are scattered all over the state and operate

"If you picture the flow of prescription drugs as a road . . . from the drug manufacturer to the patient, the Board's job is to guarantee safe conduct from start to finish."

out of their homes. It is their job to verify the information given to them by the board and to try to gauge the extent of the problem. This may involve working with the medical board or with the DEA. In some instances the investigator also may visit the local pharmacist to check prescription records or may pose as a patient and visit the physician.

Many cases are closed at this point. The investigator may determine that there is no basis to the complaint. Or he or she could find that there is a problem but it isn't criminal. For example, the physician or pharmacist could be a poor record keeper or simply not follow the proper procedures for dispensing controlled substances. Physicians, Wickham notes, are often "not the best record keepers." If it is a matter of records or procedures, the case is most often referred to the medical board who, in turn, may reprimand the guilty party.

If the investigator finds that there may be grounds for criminal action, the information is turned over to the local prosecutor or to the federal court. The investigator often continues to work with the law enforcement agencies until the case is closed.

From June of 1979 to July 1980, Jim Granecki, Assistant Director of the Board, says the agency handled 184 official complaints. Of those, 110 are still pending. This fiscal year, which ends in July, there have been 160 complaints thus far. Of those, only seven are closed. Wickham attributes the large number of open cases to recent cutbacks in budget and rising costs. Their one-half-million-dollar budget is down $100,000 from last year. And like all state and federal agencies, harsher budget cuts loom in the future.

Wickham says their job would be easier if physicians were more aware of the potential for drug abuse. The growing black market for prescription drugs has made abusers very innovative.

For example, Dilaudid is a very popular drug among street dealers and drug abusers. It is also the drug of choice for pain relief of kidney stones. To get a prescription, an abuser may visit a physician saying he is from out of town and complaining of pain in the left side. He also may mention that he has a past history of kidney stones. He usually asks the doctor for something for pain until he can see his own doctor. In many cases the physician automatically prescribes the drug. Or, if the physician is suspicious, he or she may ask the patient for a urine sample to test for blood. If that happens, the patient goes into the rest room, pricks his finger and adds a drop of blood to the urine sample. Either way, the physician is duped.

Wickham says many problems could be avoided if physicians would be more cautious when dealing with patients who are strangers, patients who request a certain drug (oh, my other doctor always gives me. . .), or even when they are treating something as subjective as pain. The potential for abuse exists in all of these situations.

Even physicians who are especially careful in treating patients can make themselves vulnerable to abusers by leaving prescription pads, hypodermic needles, and drugs in plain sight. For some patients the temptation is just too great.

Misuse of drugs also could be reduced if physicians would make certain that local pharmacies know who in their office has the authority to call in prescriptions. Wickham says the board handled a case in which a



Frank Wickham and Jim Granecki handle drug-related problems at the Ohio State Medical Board.

patient who was addicted to a certain drug called up pharmacists all over town and impersonated people from different physicians' offices. She wasn't caught until, under the influence of the drug, she made the mistake of calling the same pharmacist within a five-minute period.

However, some drug abusers go beyond taking advantage of a physician's or pharmacist's carelessness. The board has had reports of physicians — particularly those who are retired or semi-retired, who are trapped into prescribing drugs illegally because of threats to their life and property.

But not all cases of drug abuse have the physician in the role of unwitting victim. In some cases the physician is the abuser — either by using or selling drugs illegally. Most states now recognize the physician's susceptibility to these problems and have established programs — such as the OSMA's Physician Effectiveness Program — to help the physician deal with the problem.

"The growing black market for . . . drugs has made abusers very innovative."

As the abuse of prescription drugs becomes increasingly widespread, it will take continued action on the part of the board to control it. But the situation also calls for increased vigilance on the part of physicians. Wickham acknowledges that this attitude will not come easy. He says most physicians were "educated in a time when drug abuse was not a problem." Physicians today face the dilemma of balancing their patients' needs for treatment against the potential for drug abuse.

Carol W. Mullinax is Associate Director of the OSMA's Department of Communications.

Central Ohio Pharmacy's Tip Line . . .

To catch a pusher

On a typical morning pharmacist Al Keller may fill prescriptions, answer a customer's question about a new drug, and help put a stop to a drug ring.

Keller is one of two pharmacists who staff a drug "Tip Line" located in the Sharon Woods Pharmacy on Dublin-Granville Road in Columbus. The Tip Line is sponsored by the Academy of Pharmacy for Central Ohio and has been in operation for about five years.

Keller says they receive between a half dozen to a dozen calls a month, mainly from other pharmacists and from law enforcement agencies. Most calls concern stolen prescription pads, forged prescriptions, or reports of people phoning in their own prescriptions.

The line was established as a way to quickly alert area pharmacists to potential problems. It operates on a pyramid-type network with each pharmacy responsible for notifying a prearranged number of other pharmacies. When operating at peak efficiency, all 200 pharmacies in the Central Ohio area can be contacted in about half an hour. Each month, the Academy of Pharmacy also publishes the reports in its Bulletin to give each pharmacist an official record.

Suzanne Eastman, Executive Secretary of the Academy, says as far as she knows, there is only one other tip line operating in Ohio, although she has heard of other states with similar programs.

She says the Tip Line has proven to be an effective, low-cost method of letting pharmacists know "who to watch for." She encourages physicians to use the system. The number is (614) 891-1410. — CWM



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Guidelines for Prescribers of Controlled Substances

A Joint Statement of the Drug Enforcement Administration and the DEA/Practitioners Working Committee

These guidelines have been prepared under the auspices of the Drug Enforcement Administration and the DEA/Practitioners Working Committee and approved by American Dental Association, American Medical Association, American Nurses Association, American Osteopathic Association, American Podiatry Association, American Veterinary Medical Association, National Institute on Drug Abuse, and the Drug Enforcement Administration.

Approved: December 1979

Preface

The following embodies the collective thinking of members of the DEA/Practitioners Working Committee. First formed in 1974, this Committee has provided a forum for DEA officials and association executives and practitioners to meet voluntarily to discuss items, issues, and subjects of mutual interest, areas of practical concern, and generally maintain an open and responsive attitude among the various members. Having no intrinsic authority, and seeking none, the DEA/Practitioners Working Committee believes it has played a significant role in promoting the generally harmonious relationships which exist between its national organizations and their respective members. It is against this background of shared experience and knowledge that participants in the work of this Committee offer these "Guidelines for Prescribers of Controlled Substances" to members of the professions throughout the country.

Purpose

The purpose of this joint statement and the presentation of guidelines is to provide and establish acceptable professional responses to the demands of the Controlled Substances Act. The guidelines provide a common sense approach to encourage voluntary compliance by the prescribing professions.

General Statement

The principles expressed in these guidelines constitute neither a pronouncement of law nor a code of ethics, and are not intended to in any way supersede or be in conflict with statutes or ethical concepts governing the conduct of the various practitioners in their respective practices or in their respective professional organizations. Accountability is the responsibility of each discipline.

Application of State and Federal Law

Separate laws relating to the distribution of controlled substances have been enacted in most states. In many cases state law is much more stringent than federal law and will not allow certain practices which may be authorized under federal law. The guidelines are an example of good practices which should be encouraged under both federal and state laws and regulations. Close cooperation and understanding between law enforcement and medicine will ensure that legitimate drugs remain in legitimate channels.

Communication

Recognizing that members of each profession have special competencies and knowledge concerning drugs and related therapeutic agents, a free exchange of information on these matters is encouraged among the professions at all levels.

General Guidelines

- Controlled substances have legitimate clinical usefulness and the prescriber should not hesitate to consider prescribing them when they are indicated for the comfort and well being of patients.
- Prescribing controlled substances for legitimate medical uses requires special caution because of their potential for abuse and dependence.
- Exercise good judgment in administering and prescribing

"Prescribing controlled substances for legitimate medical uses requires special caution because of their potential for abuse and dependence."

controlled substances so that diversion to illicit use is avoided and the development of drug dependence is minimized or prevented.

- Guard against contributing to drug abuse through injudicious prescription writing practices, or by acquiescence to unwarranted demands of some patients.

- Each prescriber is asked to examine his/her individual prescribing practices to ensure that all prescription orders for controlled substances are written with caution.

- Make specific effort to ensure that multiple prescription orders are not being obtained by the patient from different prescribers.

Prescription Order Guidelines

The prescriber is granted through legal authority the right to prescribe medications that are necessary for the proper treatment of his/her patients. Prescribing is governed by laws and regulations which set minimum standards and requirements. These guidelines, tempered with good moral and ethical considerations, give guidance to going beyond the minimum requirements.

- The prescription order must be signed by the prescriber when it is written. The prescriber's name, address, and DEA registration number and full name and address of the patient must be given when prescribing controlled substances.

- The written prescription order should be precise and distinctly legible to enhance exact and effective communications between prescriber and dispenser.

- The prescription order should indicate whether or not it may be renewed and, if so, the number of times or the duration such renewal is authorized.

  Prescription orders for drugs in Schedules III, IV, and V may be issued either orally or in writing and may be renewed if so authorized on the prescription order. However, the prescription order may only be renewed up to five times within six months after the date of issue.

  A written prescription order is required for drugs in Schedule II. The renewing of Schedule II prescription orders is prohibited. Only in an emergency situation may oral orders for Schedule II drugs be accepted by a dispenser. Such oral orders must be followed up by a written order within 72 hours.

  Controlled substances which are prescribed without indication for renewal cannot be renewed without authorization by the prescriber.

- Prescribe no greater quantity of a controlled substance than is needed until the next check-up.

- Try to make prescription orders alteration-proof.

  When prescribing a controlled substance, write out the actual amount in addition to giving an Arabic number or Roman numeral in order to discourage alterations in written prescription orders.

  Prescribers are encouraged to consider placing a number of check-off boxes on their prescription blanks which show amounts within which the prescribed amount falls, ie, 1-25, 26-50, 51-100, over 100.

- Use a separate prescription blank for each controlled substance prescribed.

- The use of prescription blanks which are preprinted with the name of a proprietary preparation should be discouraged.

- When institutional prescription blanks are used, the prescriber should print his/her name, address, and DEA registration number on such blanks.

  Institutions should discourage the use of institutional prescription blanks for prescribing controlled substances. The prescriber should use his/her own prescription blanks in such instances.

Duty to Inform

The prescriber has the responsibility to inform patients of the effects of the prescribed drugs consistent with good medical practice and professional judgment. The patient has a corresponding duty to comply with the prescriber's directions for use of the prescribed medication.

Each of the professional organizations and the Drug Enforcement Administration have a responsibility to educate and inform the public on proper handling and use of controlled substances. The professions represented on the DEA/Practitioners Working Committee recognize that they have responsibilities to themselves, beyond legal minimum restraints.

CONTINUING EDUCATION PROGRAMS

MAY

41ST ANNUAL MEETING - OHIO STATE RADIOLOGICAL SOCIETY: May 15-17; Daytonian Hotel, Dayton; 9 credit hours; contact: Sharolene Wackman, Ohio State Radiological Society, 600 South High Street, Columbus 43215, phone: 614/228-6971.

SELECTED TOPICS IN PULMONARY MEDICINE: May 27; Lutheran Medical Center, School of Nursing Auditorium, Cleveland; sponsor: Lutheran Medical Center Foundation; 6 credit hours; fee: $50, no fee for residents and interns; contact: Mrs. B. Seidenwand, Office of CME, 2609 Franklin Blvd., Cleveland 44113, phone: 216/696-4300, Ext. 329.

AUGUST

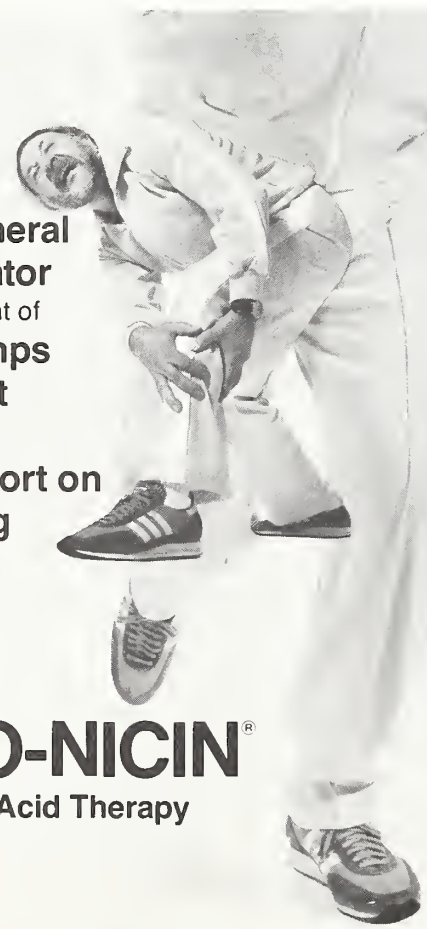
ANNUAL SCIENTIFIC ASSEMBLY-THE SICKEST FAMILY IN OHIO: August 7-9; Hyatt Regency, Columbus; sponsor: Ohio Academy of Family Physicians; 13 credit hours; no fee; contact: Mrs. Florence I. Landis, 4075 N. High Street, Columbus 43214, phone: 614/267-7867.

SEPTEMBER

UPDATE IN OBSTETRICS AND GYNECOLOGY - 1981: September 9; Atwood Lake Lodge, Dellroy; sponsor: Northeastern Ohio Universities College of Medicine; co-sponsor: Aultman Hospital; 6 credit hours; fee: $35, $22.50 (residents and nurses); contact: Alvin Langer, M.D., 2600 Sixth Street, SW, Canton 44710, phone: 216/438-6214.

INDIVIDUAL SCHEDULE

BASIC SKILLS IN MICROVASCULAR SURGERY: Individually scheduled; Cleveland Clinic Foundation, Cleveland; 40 credit hours; fee: $650; contact: Allan Cook, Cleveland Clinic Microsurgery Laboratory, 9500 Euclid Ave., Cleveland 44106, Phone: 216/444-2917.



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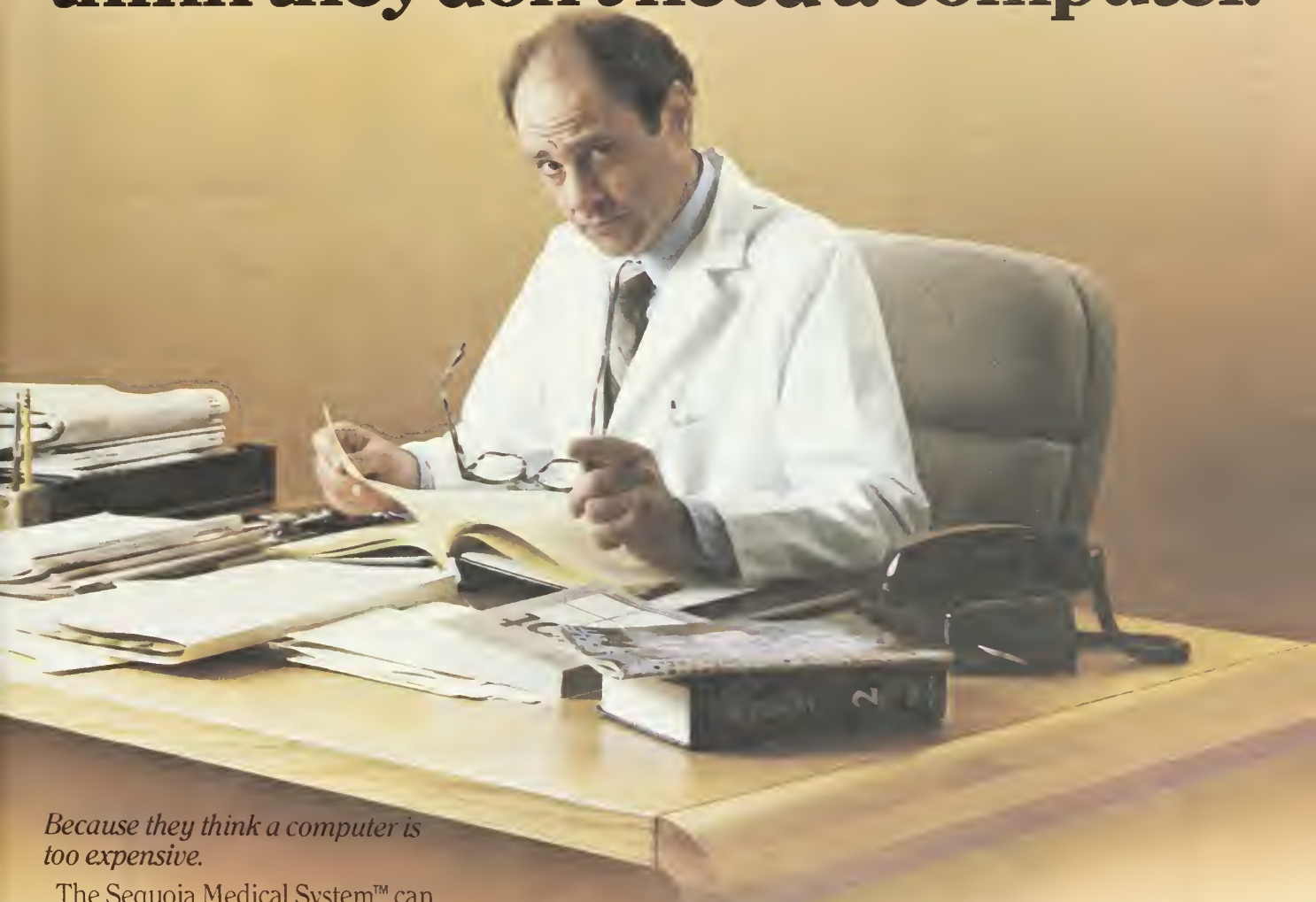
Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Obituaries

ALVIN BALES, M.D., Mansfield; Case Western University School of Medicine, 1945; age 61; died January; member OSMA and AMA.

WILLIAM R. BARNEY, M.D., Cleveland; Case Western University School of Medicine, 1914; age 90: died February 16; member OSMA and AMA.

GEORGE H. BELHOBEK, M.D., Cleveland; University of Louisville School of Medicine, 1930; died February 19; member OSMA and AMA.

CONRAD CLIPPINGER, M.D., Covington; Hahnemann Medical College and Hospital, Philadelphia, 1937; age 67; died February 9; member OSMA and AMA.

RICHARD A. FIRMIN, M.D., Zanesfield; Ohio State University College of Medicine, 1932; age 74; died January 17; member OSMA and AMA.

ARTHUR P. HOLSTEIN, M.D., Ashtabula; University of Michigan Medical School, 1940; age 67; died February; member OSMA and AMA.

OSCAR W. JEPSEN, M.D., Canal Winchester; Ohio State University College of Medicine, 1932; age 74; died February 14; member OSMA and AMA.

STEPHEN HARRIS, M.D., Steubenville; Ohio State University College of Medicine, 1927; age 82; died January 16; member OSMA and AMA.

CARL HOCHHAUSLER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1940; age 66; died January 25; member OSMA and AMA.

DONALD LEONARD, M.D., Akron; Case Western Reserve University School of Medicine, 1933; age 74; member OSMA and AMA.

LEE S. LENZ, M.D., Bonita Springs, Florida; Ohio State University College of Medicine, 1926; age 82; died February 11; member OSMA and AMA.

VALENTIN F. MERSOL, M.D., Cleveland; Loyola University Stritch School of Medicine, 1959; age 87; died February 16; member OSMA and AMA.

WILLIAM MILLBERG, M.D., Ashtabula; Jefferson Medical College, Thomas Jefferson University, 1953; age 53; died January 18; member OSMA and AMA.

RUTH RAUSCHKOLB, M.D., Cleveland; Case Western University School of Medicine, 1923; age 80; died January 22; member OSMA and AMA.

HERBERT W. SALTER, M.D., Cleveland; Harvard Medical School, 1922; age 83; died February 16; member OSMA and AMA.

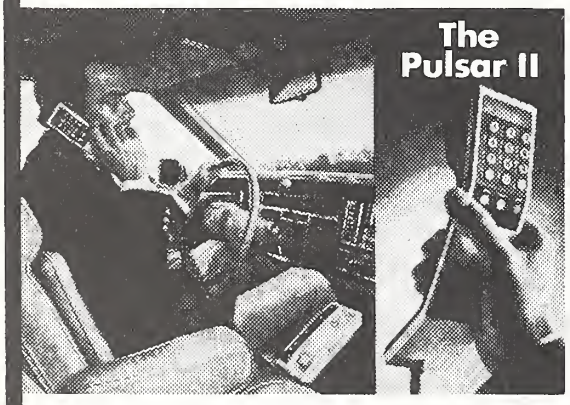
HARRY M. SALZER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1933; age 75; died January; member OSMA and AMA.

LEONARD J. STARK, M.D., Cincinnati; University of Louisville School of Medicine, 1939; age 67; died January 7; member OSMA and AMA.

CARL H. WEIDENMIER, M.D., Berlin Center; Jefferson Medical College, Thomas Jefferson University, 1927; age 80; died February 10; member OSMA and AMA.

MYRON A. WEITZ, M.D., Cleveland; Case Western Reserve University College of Medicine, 1925; age 79; died February 9; member OSMA and AMA.

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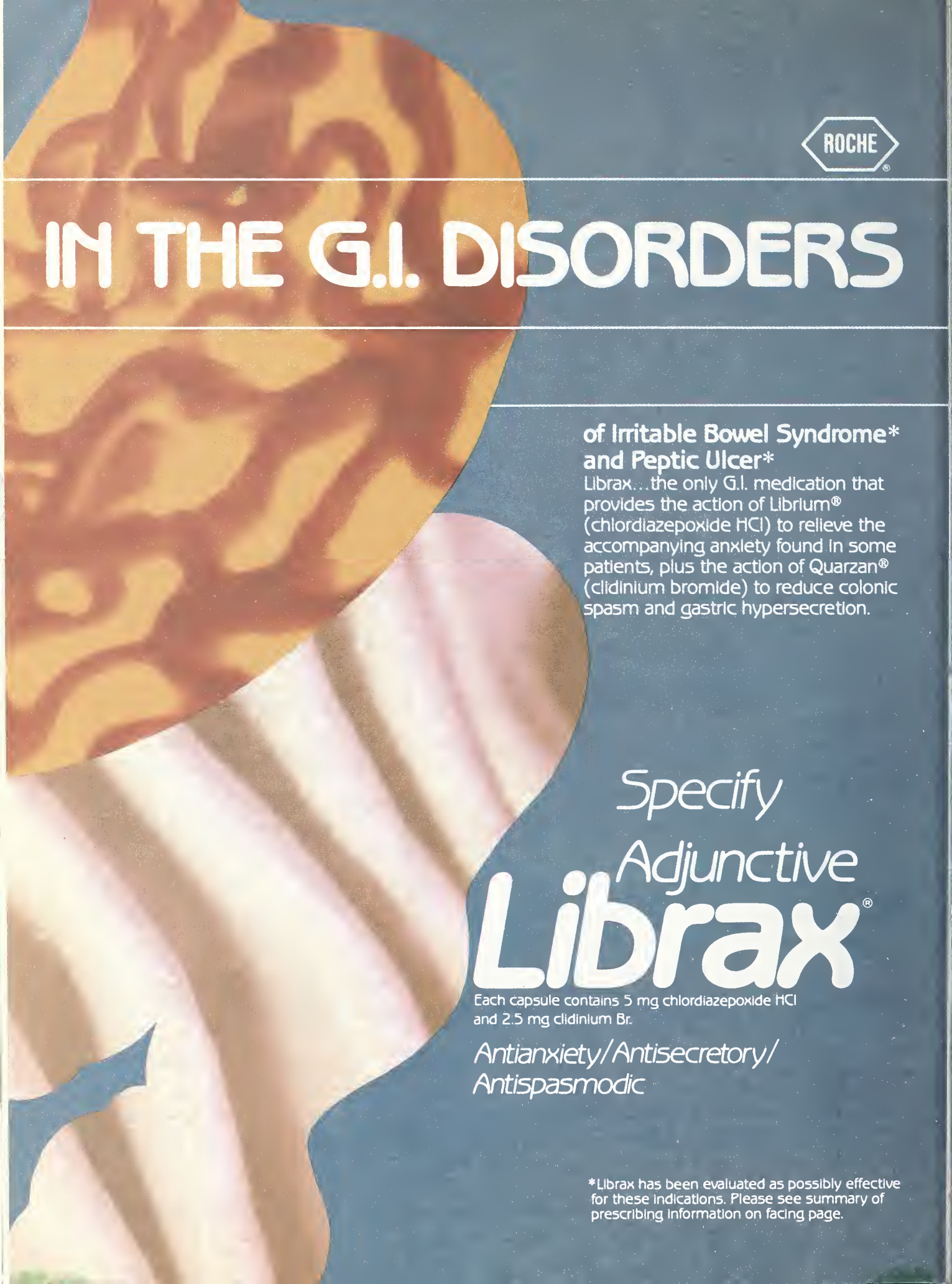
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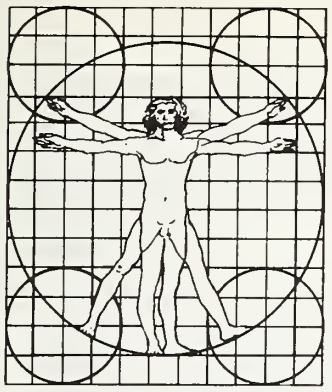
Rare Donor file program established

The American Association of Blood Banks (AABB) has established a "Rare Donor" file program, which provides a means of locating donors with appropriate blood to meet the needs of those patients who are negative for certain combinations of antigens, or for "high" frequency factors.

When a hospital has a problem case, it should contact the closest designated IH Reference Laboratory. If this laboratory does not have blood or donors available to meet the needs of the patient, it will then contact a National File, currently being maintained by the AABB, and will coordinate obtaining blood for transfusion.

A list of IH Reference Laboratories will be included in the new AABB Membership Directory, or is available upon request from the AABB National office.


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CLINICAL & SCIENTIFIC

EPISTAXIS AND THE PRIMARY PHYSICIAN

Alan J. Sogg, M.D.

Epistaxis is generally a self-limited problem due to anterior nasal septal bleeding. When the bleeding is persistent or recurrent, the primary physician usually can treat the problem by methods discussed herein.

THE PREVALENCE OF EPISTAXIS is evidenced by its occurrence in all age groups. It is a problem many physicians are only too happy to refer. However, many patients with epistaxis can be treated by their primary physician.

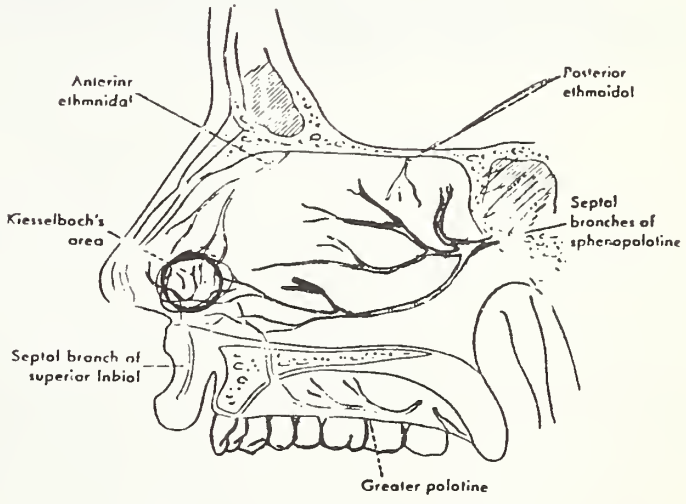
Most bleeding is anterior septal, particularly in the pediatric age group, and is self-limited. Upper respiratory infections are probably the most common cause of epistaxis, though it may occur spontaneously or be traumatic in origin. The trauma can be in the form of a finger, direct trauma to the nose, drying of the mucosa because of dry, warm indoor air during the cold weather, or even sneezing.

Knowledge of the blood supply of the nose is helpful in determining appropriate treatment. The nasal septum is depicted in the figure.

The circled area of the diagram is known as Kiesselbach's area or plexus and is the usual anterior bleeding site. The bleeding can be controlled fairly easily by direct pressure to the bleeding area. This can be done with a piece of cotton soaked with phenylephrine solution and then partially squeezed out. The cotton is placed in the nostril over the bleeding area and the nostrils are pinched firmly so that the direct pressure is on the bleeding area. The pressure is maintained for several minutes.

Cauterization of the bleeding area with chemical cautery such as silver nitrate may be necessary in the patient with repeated episodes of epistaxis. The area first is anesthetized by application of cotton soaked with a local anesthetic (5% to 10% cocaine is ideal since cocaine not only gives excellent local anesthesia, but it is also a vasoconstrictor). The bleeding vessel(s) then is coagulated with the silver nitrate stick.

Electrocautery will accomplish the same thing, but the form of anesthesia must be either general or by injection, as this



Arteries of the nasal septum.

Dr. Sogg, Cleveland, Assistant Clinical Professor, Case Western Reserve University School of Medicine.
Submitted April 7, 1980.

cauterization is deeper than the surface cautery of the silver nitrate, and requires more than the surface anesthesia of cocaine or xylocaine. Should the local form of cautery and/or pressure not control the bleeding, an anterior pack, preferably inserted under local anesthesia, may be necessary. The pack usually is left in place for 48 hours.

The management of the patient with bleeding from areas other than the anterior septum is more complicated. Good illumination, knowledge of the intranasal anatomy and the proper equipment all are helpful, if not mandatory. If the bleeding is posterior, a posterior pack is inserted, and most likely an anterior pack will be necessary.

The patient who has a posterior pack also should be hospitalized and given oral antibiotics since the packing and the retained nasal secretions will cause blockage of the sinus ostia with resultant infection. Codeine or morphine often will be needed for pain by the patient who has a posterior nasal pack.

More unusual causes of epistaxis should be considered. These come under the general headings of infections and neoplasms, either primary or metastatic, and benign or malignant. Metabolic and hematologic problems also can cause epistaxis.

Anterior nasal bleeding is handled best by pressure to the bleeding site and cauterization when necessary. Packing may be required when other control methods are unsuccessful.

The indications for posterior packing and other causes of epistaxis are mentioned herein.



PLACEMENT SERVICE ADS



In order to promote retention in Ohio of physicians who trained in the State, ***The Journal***, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of ***The Journal***. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See previous issues of ***The Journal*** for additional listings.)

INTERNIST: With cardiology subspecialty. Diplomate of Board of Internal Medicine and eligible in cardiology in November 1981. Available September 1981. Wishes solo or group practice with part-time academic appointment in community with population under 500,000. Would consider various settings including inner city in areas 1, 2, 3 or 5. Contact Box P-83 c/o Ohio State Medical Journal.

INTERNIST: With rheumatology subspecialty. Desires solo or group practice with part-time academic appointment. Prefers community with at least 50,000 people in southern half of Ohio. Seeking suburban metropolitan, metropolitan or inner city location. Board-eligible in 1979 and available for practice July 1981. Contact Box P-76 c/o Ohio State Medical Journal.

INTERNIST: With subspecialty of cardiology desires community that is rural with metropolitan ties, suburban metropolitan or metropolitan with 15,000 to 100,000 people. Interested in solo or group practice. Diplomate of the Board of Internal Medicine and eligible in cardiology in 1981. Contact Box P-80 c/o Ohio State Medical Journal.

INTERNIST: With subspecialty of endocrinology and metabolism. Board-eligible in internal medicine in 1979 and in endocrinology in 1981. Interested in solo or group practice and part-time academic appointment. Contact Box P-82 c/o Ohio State Medical Journal.

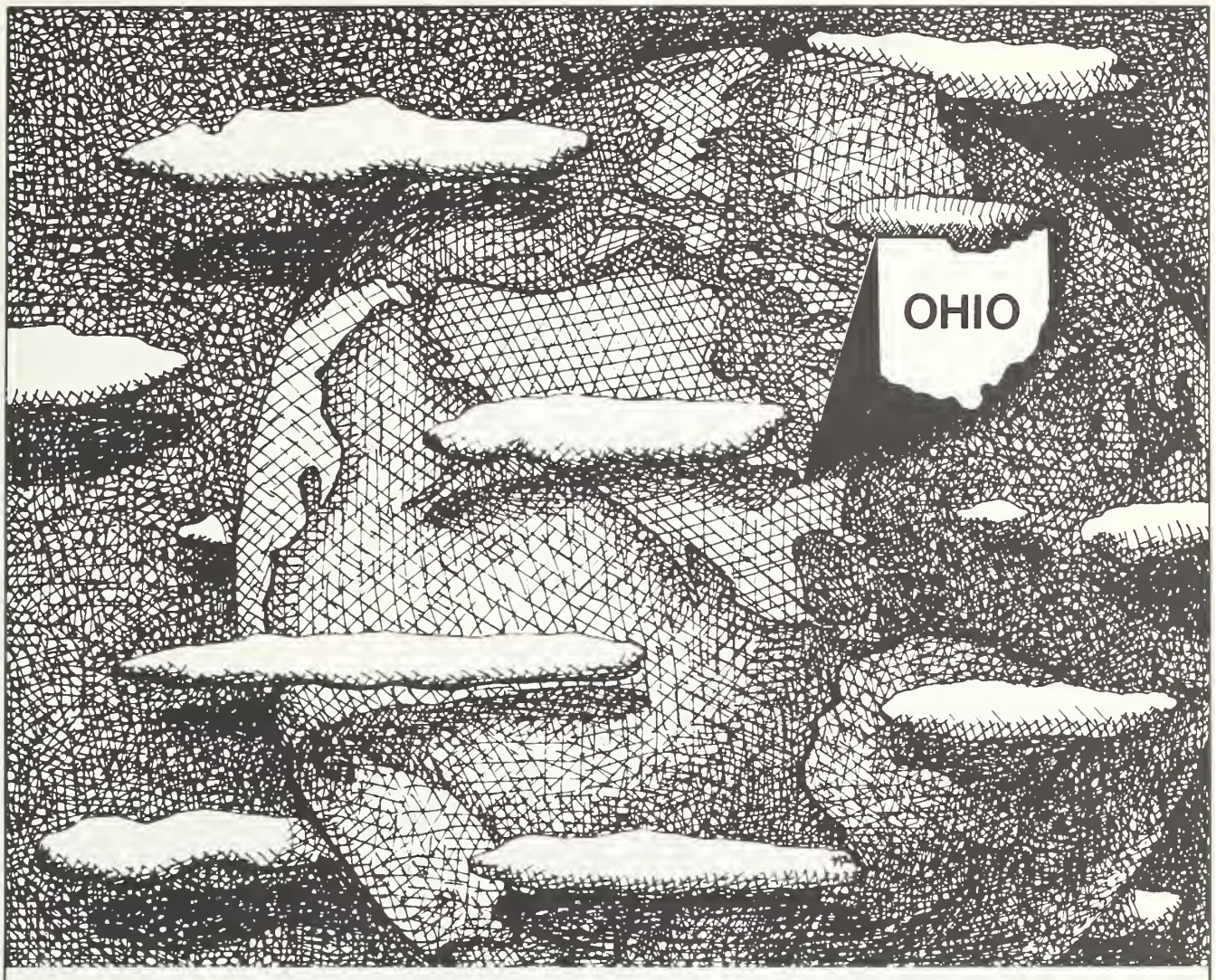
SURGEON: General with subspecialty of peripheral vascular surgery. Board-eligible in June 1981 and available in July 1981. Prefers solo or small group practice in community that is rural with metropolitan ties and has population under 50,000. Contact Box P-81 c/o Ohio State Medical Journal.

INTERNIIST: Available December 1979. Interested in solo or small group practice in community that is rural with metropolitan ties or suburban metropolitan with population of 15,000 to 500,000 anywhere in Ohio but area 4. Eligible for specialty board December 1979. Contact Box P-51 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty. Diplomate of the Board of Internal Medicine; in July 1980 will be eligible in cardiology and available. Full-time academic appointment desired in suburban metropolitan or metropolitan community of 50,000 or more people. Contact Box P-61 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

INTERNIST: Trained in invasive and noninvasive cardiology. Diplomate of the Board of Internal Medicine; available July 1980 and eligible in cardiology June 1981. Desires solo or group practice in community of 30,000-100,000 people, rural with metropolitan ties, suburban metropolitan or metropolitan. Contact Box P-65 c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

SURGEON: Cardiovascular thoracic with general and transplantation surgery secondary specialty. Available July 1980. Desires suburban metropolitan or metropolitan community of 50,000 or more people. Interested in solo, small group or institutional practice and/or academic appointment. Has passed specialty board examination in general surgery; eligible in cardio-thoracic July 1980. Contact Box P-50 c/o Ohio State Medical Journal.



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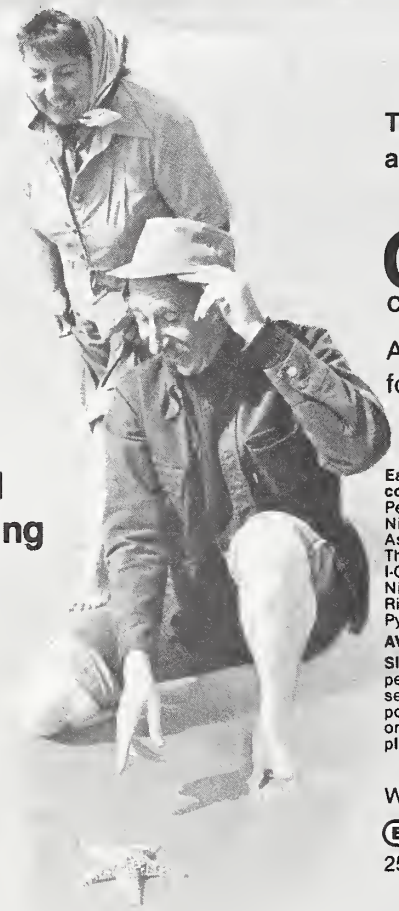
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Physician Statistics Now Available

According to the American Medical Association's recent publication "Physician Distribution and Medical Licensure in the U.S., 1979," there were 454,564 physicians in the U.S. and possessions, as of December 31, 1979. This is an increase of 17,078 over the previous year. Of the final total, 356,783 physicians were listed as being directly involved in patient care; 96,605 were listed as foreign medical graduates, and 50,604 were listed as women physicians. Those interested in further statistics may obtain a copy of the volume from: Order Department (OP 300), American Medical Association, P.O. Box 821, Monroe, Wisconsin 53566.



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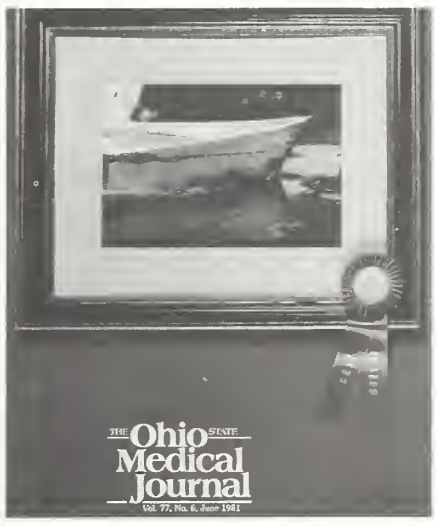
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Our Cover

"The Boat" by Vera Kalnins was selected the "Best in Show" winner from over 70 entries in this year's Journal Photographic Exhibit contest. This is her second consecutive year for the honor, as her photograph of "Strawberries" captured the 1980 "Best in Show" title. "The Boat" was taken with a Nikon F2A camera, equipped with a 135 mm Nikkor Lens, and using Kodak Ektachrome 200 film.

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Letters ...to the editor

Preventive politics

To the Editor:

This will refer to the April, 1981 issue of the *Ohio State Medical Journal's* article on "Forging New Alliances."

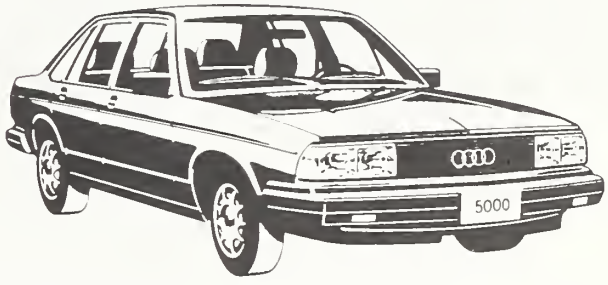
It would seem to me that politicians should practice preventive politics and begin to enforce some of the laws concerning air pollution in Belmont County. The EPA in Steubenville has been asked to stop air polluters in Bridgeport, Ohio over the past ten years. The only thing they have stopped is the one employee of EPA in 1972 (who declared a polluter as a public nuisance) by removing him from office.

It is my opinion the EPA should be abolished in Belmont County, if the victims of pollution must sue the polluter. Why should taxpayers do the work and let the EPA officials sit on their tails and collect salaries for doing nothing to correct a situation for which they are paid?

Sincerely yours,
/s/Leo W. Zadinsky, M.D.

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COLLEAGUES IN THE NEWS



Dudley Briggs, M.D.

DUDLEY F. BRIGGS, M.D., Columbus, was elected to the board of directors of the American Occupational Medical Association. Dr. Briggs retired as a surgeon in 1973 and since 1970 he has been an assistant clinical professor of preventive medicine at the Ohio State University. Dr. Briggs is active in numerous medical societies and is currently a literature reviewer for the Journal of Occupational Medicine.

City Health Commissioner **STANLEY E. BROADNAX, M.D.,** Cincinnati, was appointed a trustee of the United States Conference of City Health Officers. Dr. Broadnax will work with other city representatives to upgrade health services in communities across the country.



Alford C. Diller, M.D.

ALFORD C. DILLER, M.D., Bellefontaine, was elected president of the West-Central Ohio Health Systems Agency. Dr. Diller is chairman of the Statewide Health Coordinating Council and previously served as WCOHSA president from March 1978 to March 1980.

BURTON W. EVANS, M.D., Cincinnati, was elected president of the Deaconess Hospital medical staff. Dr. Evans currently is secretary of the Ohio Valley Proctologic Society.

ROBERT E. GREGORY, M.D., Cincinnati, was elected president of the medical/dental staff of Children's Hospital Medical Center. Dr. Gregory is past president of the Cincinnati Pediatric Society and clinical professor of pediatrics at the University of Cincinnati College of Medicine.



Alfred L. Weiner, M.D.

SANDER GOODMAN, M.D., STANLEY SIMON, M.D., and MARK HOEKENGA, M.D., Cincinnati, were named to Drake's Honorary Medical Staff for their years of dedicated service to the hospital. They were former medical directors and long-time staff members of Drake Memorial Hospital.

ROBERT HEIDT, M.D., Cincinnati, was elected president of the Ohio Orthopaedic Society. Dr. Heidt currently is president of the medical staff of Christ Hospital.

CLARENCE L. HUGGINS, JR., M.D., Cleveland, was voted chairman-elect of the Ohio Medical Care Advisory Committee.

ALFRED L. WEINER, M.D., Cincinnati, was recognized and honored as the founder and charter president and for his many contributions and services to the Noah Worcester Dermatological Society by the establishment of the Alfred L. Weiner Annual Lectureship of the Society. Dr. Weiner is clinical professor of dermatology at the University of Cincinnati Medical Center, past president of the Cincinnati Dermatological Society and secretary-treasurer of the Masters Dermatologic Association.

WILLIAM WELLS, M.D., Newark, was appointed to serve on the Advisory Council to the Board of Nursing Education and Nurse Registration.

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Following is a list and brief description of recent bills introduced into the Ohio General Assembly:

HOUSE BILL 352 — (Saxbe, R-Mechanicsburg) STATE OFFICER IMMUNITY

HB 352 would entitle individuals who render "medical, dental, psychiatric, or psychological services to wards of the state," as an employee of or pursuant to a personal services contract with an agency of the state, to representation, immunity, or indemnification in civil actions arising from the delivery of such services. Drafted by the Department of Rehabilitation and Corrections, at the request of the OSMA, the bill is being heard in the House Health and Retirement Committee.

HOUSE BILL 353 — (Zehner, D-Yellow Springs) NURSING HOME REGULATION

HB 353 is a redraft of Senate Bill 200 (Stano, D-Parma) from last session and revises Ohio's nursing/rest home laws. The bill creates the Office of Chief Inspector of Nursing Homes, establishes receivership procedures by which to appoint health care receivers to operate nursing homes that have violated regulations, and requires anyone working with home residents to report suspected cases of abuse or neglect. HB 353 has been referred to the House Aging and Housing Committee.

HOUSE BILL 418 — (Guerra, R-Englewood) BLOOD ALCOHOL TESTING IMMUNITY

HB 418 permits a physician or a registered nurse to refuse to withdraw blood, if "in their opinion the physical welfare of the person would be endangered by the withdrawing of blood." The bill also grants immunity from criminal prosecution or assault and battery to a physician or registered nurse who withdraws blood for alcoholic content analysis. The bill is being heard in the House Civil and Commercial Law Committee.

HOUSE BILL 435 — (Tranter, D-Cincinnati) HOSPITAL BONDS

HB 435 repeals the authority of the state to issue revenue obligations through the Ohio Higher Educational Facility Financing Commission for the acquisition or improvement of hospital facilities. This authority was enacted on the last day of last session.

HOUSE BILL 442 — (Carney, D-Boardman) PHYSIATRIST PHYSICAL THERAPY LICENSURE

HB 442 permits a physiatrist to register with the Ohio Occupational Therapy and Physical Therapy Board for licensure as a physical therapist without taking the state's physical therapy examination or paying a license fee. HB 442 has been referred to the House Health and Retirement Committee and is opposed by the Physical Therapy Board.

HOUSE BILL 452 — (Cook, D-Cuyahoga Falls) GOOD FAITH EFFORT

Introduced with the support of most of Ohio's Blue Cross plans, HB 452 eliminates the requirement that a plan prove it has made good faith efforts to control costs, in order to gain Insurance Department approval of contracts, formulas, and notes. Replacing the "good faith" language is a proposal to levy the state's corporate franchise tax against Blue Cross plans with a system of tax credits that are dependent on certain cost containment activities. By meeting each of the eleven (11) cost containment requirements, a Blue Cross plan would be entitled to a tax credit of one-eleventh (1/11) of its corporate franchise tax liability. HB 452 has been assigned to the House Insurance Committee.

HOUSE BILL 469 — (Mahnic, D-Cleveland) C.O.N.

HB 469 is a reintroduction of last session's Senate Bill 291. The bill modifies Ohio's certificate-of-need law pursuant to federal statutes. HB 469 has been referred to the House Health and Retirement Committee.

HOUSE BILL 495 — (Galbraith, R-Maumee) ABORTION FUNDING FOR ADC MOTHERS

HB 495 requires county welfare departments to pay up to five hundred dollars ($500) on request to ADC mothers for abortions or tubal ligations. The bill has been referred to the House Finance and Appropriation Committee.

HOUSE BILL (no number assigned) (Fisher, D-Shaker Heights) MANDATORY CHILD RESTRAINT SYSTEMS

Representative Lee Fisher has drafted but not yet introduced legislation to require that a child less than four years old or weighing under forty pounds be secured in a child restraint system when being transported in a vehicle owned by the child's parent or guardian. Violation of this requirement would result in a penalty of two points on the driving record of the vehicle operator. The legislation permits a state income tax credit of the lesser of five dollars ($5.00) or ten percent (10%) of the expense of purchasing and installing a child restraint system in a motor vehicle.

HJR 19 — (J. Thompson, D-Cleveland) NURSING SHORTAGE STUDY

House Joint Resolution 19 establishes a committee to study the shortage of nurses in Ohio and make recommendations for relieving the shortage. The committee will have ten members, five from the House (appointed by the Speaker) and five from the Senate (appointed by the President of the Senate). The Resolution requires the ad hoc committee to submit a comprehensive final report, which includes recommendations, and dissolve within a year after the adoption of the resolution. The resolution passed the House and awaits committee referral in the Senate.

HJR 22 — (T. James, D-Cleveland) DEAF COMMISSION STUDY

House Joint Resolution 22 establishes a committee to study the need for a Commission for the Deaf and Hearing Impaired. The committee will consist of eleven legislators: six representatives appointed by the Speaker of the House and five senators appointed by the President of the Senate. The resolution requires the committee to report its findings to the 114th General Assembly "at the earliest possible date." Legislation establishing a Commission for the Deaf and Hearing Impaired, HB 805, was introduced by Representative James in 1979. HB 805 passed the House but received no floor vote in the Senate. HJR 22 has passed by the House Health and Retirement Committee and awaits House floor approval.

HJR 27 — (T. James, D-Cleveland) MEDICAID SUBSIDIES

House Joint Resolution 27 petitions Congress to grant an additional Medicaid subsidy to those states whose annual average unemployment rate for the previous year exceeds the average national unemployment rate. Ohio would qualify for more Medicaid subsidies, according to the proposal, by virtue of its position as the "second most economically depressed state." HJR 27 passed the House and has been sent to the Senate for consideration.

SENATE BILL 136 — (Van Meter, R-Ashland) BLUE CROSS DIFFERENTIAL

SB 136 prohibits any hospital from accepting payments from any third-party payor at a reduced rate or price differential in return for economic benefits or services provided by the third-party payor. The bill defines as an "unfair trade practice" the refusal by a hospital to accept reduced rates from a third-party payor offering similar services, if the hospital accepts reduced rates from another payor.

SENATE BILL 148 — (Skall, R-South Euclid) GUILTY BUT MENTALLY ILL VERDICT

SB 148 creates the plea and verdict "guilty but mentally ill." To be found "guilty but mentally ill," the defendant must be found sane at the time the alleged offense was committed. Under the bill, treatment for mental illness must be included in the sentence for someone found guilty but mentally ill. The bill is before the Senate Judiciary Committee.

SENATE BILL 159 — (Kasich, R-Westerville) SPORTS PHYSICIAN IMMUNITY

SB 159 provides immunity from civil liability to physicians and others who provide emergency care to participants in a school athletic event unless the treatment constitutes willful or wanton misconduct.

SENATE BILL 173 — (Nabakowski, D-Lorain) HOSPICE REIMBURSEMENT

SB 173 requires all medical care corporations which provide coverage for medical care to provide coverage for hospice services, beginning in 1982. "Hospice" is defined in the bill to mean "a centrally administered program of palliative and supportive services that provides physical, psychological, social, and spiritual care on a short-term basis for dying persons and their families." The bill requires hospices to be licensed annually through the Department of Health and establishes an eight-member hospice advisory board to advise the Public Health Council in the development of hospice regulatory rules.

SENATE BILL 270 — (Finan, R-Cincinnati) COURT-REFERRED PATIENTS TO COMMUNITY MENTAL HEALTH FACILITIES

SB 270 requires community mental health facilities to accept any patient referred by a probate court. Before a court-referred patient may be discharged from a hospital, the hospital would be required to notify the probate court, the prosecuting attorney, and the Attorney General. SB 270 has not been referred to committee.

SENATE BILL 271 — (Finan, R-Cincinnati) EMERGENCY MEDICAL SERVICES AGENCY

SB 271 establishes an Emergency Medical Services Agency within the Department of the Adjutant General. In cooperation with the Emergency Medical Services Council, the Agency would seek to establish EMS programs in those areas of the state where there are none now, and coordinate the services of currently operating EMS programs. The bill has not been referred to committee.

SENATE BILL 301 — (Schwarzwalder, D-Columbus) — GENERIC DRUG PROFITS

SB 301 amends Ohio's generic drug statute to permit pharmacists the same total profit for dispensing generic drugs as allowed for dispensing the equivalent brand name drugs. SB 301 has not been assigned to committee.

SENATE BILL 308 — (Aronoff, R-Cincinnati) HEALTH PLANNING

SB 308 was drafted by the Ohio Department of Health to track Ohio's health planning and certificate-of-need law with changes in federal statutes and rules. Under the bill, many aspects of Ohio's law would change with revisions in the federal act. The bill has not yet been assigned to a committee.

SENATE BILL 315 — (Kasich, R-Westerville) ABORTION INFORMED CONSENT

SB 315 is the Senate version of HB 92 (Rocco, D-Parma), requiring a detailed informed consent prior to an abortion and establishing juvenile court procedures by which a pregnant unmarried minor must obtain court consent to have an abortion. Both SB 315 and HB 92 contain the informed consent language proposed by HB 879 (Rocco, D-Parma), the abortion bill from last session. (See **House Bill 92, this Legislative Update**). SB 315 has not yet been assigned to committee.

SENATE BILL 329 — (Skall, R-South Euclid) COUNSELOR AND SOCIAL WORKER LICENSURE

SB 329 requires the licensure and registration of counselors and social workers under qualification standards established in the bill, and establishes a nine-member Counselor and Social Worker Board appointed by the Governor. The bill would exempt physicians and other state-licensed professionals from regulation as long as the services they perform are within the "recognized scope, standards, and ethics of their respective professions." The bill has not yet been assigned to committee.

SENATE BILL 343 — (Valiquette, D-Toledo) HOSPITAL PATIENTS' RIGHTS

SB 343 is very similar to the hospital patients' rights legislation proposed by Senator Valiquette in the last two sessions. In part, SB 343 guarantees hospital patients the right: to know the name of their doctor and his specialty, to privacy, to explanation of the hospital bill, to change hospital staff physicians, emergency medical treatment, regardless and without discussion of ability to pay, to inspect all legally accessible records, and to know all relevant and current information concerning diagnosis and prognosis. The nineteen proposed rights are granted some degree of latitude through phrases such as "if reasonably possible," "within the capacity of the hospital," and "reasonably foreseeable medical consequences." The bill has not been assigned to committee.

SENATE BILL 365 — (Van Meter, R-Ashland) MENTAL OUTPATIENT COVERAGE FOR ALCOHOLISM

SB 365 requires that certain health insurance contracts offer outpatient coverage for mental and emotional disorders, and outpatient, inpatient, and residential care coverage for alcoholism treatment. The bill, in effect, removes the sunset clause from SB 90 of the 112th General Assembly. The bill has not yet been assigned to committee.

SENATE JOINT RESOLUTION 20 — (Finan, R-Cincinnati) — RIGHT-TO-LIFE CONSTITUTIONAL AMENDMENT

Senate Joint Resolution 20 petitions Congress to call a constitutional convention for the purpose of adding an amendment "guaranteeing the right to life to the unborn." The resolution, which is strongly supported by anti-abortionists, has not yet been assigned to committee.



SECOND OPINION

Personalized medical education

By John W. Martin, M.D.

The following thoughts are in no sense meant as a criticism of the directors of the Ohio State Medical Association, who have done a magnificent job in organizing and improving medical education in Ohio. It is our hope in this discussion we may be able to suggest certain alterations in the medical education effort that may be helpful. All of us have special methods of learning. If we could only fit the subject and the method of teaching to the individual, it would be a great improvement. Admittedly, this is a tall order but certainly worth the effort.

At present, in most community hospitals, as a means of obtaining Category I credit, formal lectures are given to educate the entire staff. This method certainly has its merits.

Preplanning with a well-organized syllabus and selected references is helpful. A list of stated objectives is a definite need and an evaluation of the learning session is essential. But there are shortcomings that all directors of medical education realize.

It is difficult to find a large number of Category I subjects that are of general interest. There is need for subjects that meet individual needs. A dermatologist has little interest in digitalis, the pediatrician cares little about geriatrics, and the geriatrician has minimal desire to learn about the feeding of babies. We are all properly concerned about our own particular learning requirements.

All too often physicians go to lectures mainly to accumulate Category I credits. Personal requirements are not satisfied. This leads to frustration, confusion, and boredom.

In the general lecture format, we must select our material carefully so that it will be appropriate for a general community hospital audience. Secondly, when important subjects of general interest are to be discussed such as electrolytes, fluid balance, or antibiotics, it is essential we give enough time for proper understanding. These sessions of involved subjects should not be treated on a simple one-hour lecture basis, but should be more thoroughly discussed over a period of some weeks, or in a panel covering four to five hours. There should be time for personal preparation before going to the lectures so that pertinent information can be readily absorbed. This would encourage further audience discussion after the lecture and intensify the learning process.

But even a well-developed lecture program giving adequate time to subjects of general interest is incomplete. Specific needs for individual members of the staff are neglected. Various specialty groups should be encouraged to keep up to date in their own areas of interest.

To establish individual requirements, it is suggested that:

1. Each member of a specialty group should personally make a list of subjects in which he is deficient.
2. Each division chief could add his thoughts considering department shortcomings.
3. Reports from the record room, quality assurance, and tissue committees could further help define the needs within various departments. With information from the above sources, a more suitable program could be organized for different departments.

But even after this is done, the individual fit is not **precise.** Each person within the group should continue to focus on his own particular deficiencies. He should organize his own methods of attack adapting for his particular needs and learning abilities.

This might include a well-organized study program — perhaps using such material as is available from the American College of Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, or American College of Surgeons, etc. Needless to say, a well-stocked, up-to-date library of carefully selected books, journals, and audiovisual material is a cornerstone for CME. Equally important is an enthusiastic, intelligent, well-trained librarian who will facilitate the search for knowledge.

Others who learn more easily from discussions might do well to organize small journal clubs of four to five

Continued on page 346

John W. Martin, M.D., is an OSMA member and a co-director of Continuing Medical Education at Hillcrest Hospital in Mayfield Heights, Ohio.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by Karen S. Edwards

Pediatric chest x-rays deemed unnecessary

Routine use of chest x-rays as a screening device before elective surgery on children should be stopped, since the procedure seldom finds conditions which result in either cancelling the operation or preventing postoperative complications, a newly published study says.

An article reporting these findings appears in the April issue of *Pediatrics*, the official journal of the American Academy of Pediatrics. Conducting the study were Robert A. Wood and Robert A. Hoekelman, M.D., both of the Department of Pediatrics at the University of Rochester's School of Medicine and Dentistry, Rochester, N.Y.

In view of the "low yield of significant information" discovered by routine chest x-rays before elective surgery, Wood and Dr. Hoekelman recommend that the now common practice be stopped. These tests, they say, should be performed only on an individual case basis. Their recommendation also covers chest x-rays which often are routinely performed on children admitted to hospitals for nonsurgical reasons, and chest x-rays performed for other screening reasons, such as a prerequisite for entering college.

Ovarian cancer cases collated by Registry

Increasing reports of ovarian cancer in two or more family members have led the Familial Ovarian Cancer Registry of Buffalo, New York, to collate cases of familial ovarian cancer for evaluation.

The cases they accumulate will be evaluated for:

- The number of cases of familial ovarian cancer
- The type of inheritance
- The relationship to breast and endometrial carcinoma
- The study of environmental, geographical and racial factors
- Genetic counseling

Physicians who can give the clinical history of any family with two or more members with ovarian cancer are asked to contact: The Familial Ovarian Cancer Registry, Roswell Park Memorial Institute, New York State Department of Health, 666 Elm Street, Buffalo, New York 14263.



PSRO: Sinking slowly on government's horizon

Joseph F. Boyle, M.D., Vice Chairman of the American Medical Association's (AMA) Board of Trustees, spoke for the Association before subcommittees of the Senate Finance Committee and the House Ways and Means Committee on the growing unrest among physicians over the federal direction and implementation of the PSRO program.

"In supporting termination of the PSRO program, I want to emphasize that the AMA remains a staunch advocate of peer review as a mechanism to assure high quality medical care. However, in attempting to federalize peer review, the government has misdirected the professional objectives of peer review to assure high quality care, and has inappropriately focused the PSRO program principally on containing costs.

Dr. Boyle explained the Association's change in position on the PSRO program after nine years of support, was "a natural, eventual result," based upon growing dissatisfaction with federal bureaucracy and fruitless attempts to improve the PSRO program.

However, he strongly emphasized that the Association's recommendation for termination of the PSRO program should not be considered a withdrawal of support for professional peer review. "What the AMA is rejecting is a federally directed review program where the federal direction is no longer interested in patient care or quality service, but to the single-minded purpose of restricting health expenditures.

Meetings

Third Annual Gerontology Forum: July 20-24, Sheraton-Mansfield Conference Center, Mansfield, Massachusetts. Twenty programs will be presented which will be of particular relevance to practitioners and the public, facing the future of aging in America. Full-day workshops and evening events are planned. For further information, contact: New England Consortium for Gerontology, 15 Garrison Ave., Durham, New Hampshire 03824.

Neurosurgery 1981: August 6-8, Palmetto Dunes Hyatt Resort, Hilton Head Island, South Carolina. This symposium offers an intensive review and discussion of the subjects: Pediatric Surgery, Recent Advances in Spinal Disorders and Neuro-otology. Fee: $350. Credit: 20 hours, Category 1. For further information, contact: Hilton Head Island Neurosurgical Symposia, 506 Oak Street, Cincinnati, Ohio 45219.

Second National Seminar on Community Cancer Care: September 25-27, Hyatt Regency, Indianapolis, Indiana. Sponsored by the Clinical Oncology Center and the Graduate Medical Center at the Methodist Hospital of Indiana, Inc. For further information, contact: Office of Continuing Medical Education, Methodist Hospital of Indiana, Inc., 1604 N. Capitol Ave., Indianapolis, Indiana 46204.

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Pocket Guide to Injectable Drugs. *By Lawrence A. Trissel, American Society of Hospital Pharmacists. $10.00.*

This convenient pocket guide provides instant and detailed information on dosage (including pediatrics), administration, reconstitution, stability and compatability of injectable drugs, as well as a complete cross-index of the drugs' generic and proprietary names.

Its unique format is designed to give quick answers to the most commonly asked questions, and its index to the Handbook of Injectable Drugs, and the American Hospital Formulary Service, aids in resolving more complex problems.

The book is 175 pages, softbound. Copies can be obtained from the American Society of Hospital Pharmacists, Publication and Membership Records, 4630 Montgomery Avenue, Washington, D.C. 20014.

Blood Pressure Control. *Thomas G. Coleman, Pergamon Press, Inc. $32.50.*

The mechanisms that control blood pressure, keeping it within the delicate and narrow range vital for life, are shrouded in mystery. However, medical research in this area is expanding rapidly and general theories are emerging from experimental data. This book contains the most recent laboratory and clinical findings brought together for review and analysis. Those with an interest in hematology, cardiology, or related fields will find this book a unique and invaluable reference tool. For further information, or to request a copy of the book, contact Pergamon Press, Inc., Maxwell House, Fairview Park, Elmsford, N.Y., 10523.

Myocardial Protection in Regional and Global Ischemia, Volume 1. *By R. Chu-Jeng Chiu, Pergamon Press, Inc., $26.00.*

This new series records the results of the latest significant research on myocardial protection in regional and global ischemia. Contents include the Rationale for Infarct Size Reduction, Metabolic and Nutritional Substrates and Results of Comparative Studies in Myocardial Protection during Cardiac Surgery. For further information, or to request a copy of the book, contact Pergamon Press, Inc., Maxwell House, Fairview Park, Elmsford, New York 10523.

Clout in the drug industry: Who's got it?

If you've been wondering who has the most clout in the drug industry these days, the five "most influential people in the drug delivery system" were recently selected in a poll of key national pharmaceutical scene observers, and profiled in an issue of *Drug Topics*, the newsmagazine distributed twice monthly to the drugstore market.

Selected in the poll were:

Sidney Dworkin, president and chief executive officer of Revco, who pioneered the "deep discount" concept in the retail marketing of pharmaceuticals.

Lewis A. Engman, president of the Pharmaceutical Manufacturers Association.

William S. Apple, president of the American Pharmaceutical Association, who helped along the rapid growth of generic drugs.

Irwin Lerner, president and chief executive officer of Hoffman-LaRoche.

Sidney M. Wolfe, M.D., head of Ralph Nader's Public Citizen organization and director of its offshoot Health Research Group.

According to key Washington observers of drug regulation, law, marketing and professional practice, these five were voted most likely to "get things done."

Second opinion (continued)

interested physicians to read, digest, and discuss pertinent subjects. The more arguments on pros and cons, the better; it helps the memory.

Hopefully, our present system of medical education with its emphasis on Category I and a confusing number of subcredit categories might be modified for the better. There should be rather less emphasis on form and more substance. More effort should be made on getting useful knowledge to the individual physician so that he may give better patient care and service.

Drs. Thomas Meyer, Paul Tracy, and Sigurd Sivertson reflect these views in an article published in the *Quarterly Review Bulletin* of January 1981, in which they agree that the present system does not take into account various learning styles, and forces physicians to participate in potentially unproductive learning experiences.

In the future it is hoped that there will be more emphasis on individual needs — more **personalized medical education.** OSMA





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An OSMA committee report

Pregnancy and Medical Disability

By John Sanders, M.D., Willys Woodward, M.D., and Charles V. Bowen, M.D.

(Members of the OSMA Committee on Maternal and Neonatal Health.)

When are pregnant patients eligible for total medical disability?

That question proved to be a major discussion point between physicians and industry medical directors at a conference recently held in Akron by a subcommittee of the Ohio State Medical Association's Committee on Maternal and Neonatal Health.

The subcommittee on Pregnancy Occupational Disability found that there are still physicians who are unaware of the laws which state that pregnancy must be treated as any other illness within company benefit programs.

"The growth in numbers of women in the work force is becoming significantly greater," says Francis Y. Folck, Jr., of the University of Michigan's School of Public Health. "Out of a total work force of 100 million individuals, women comprise 42 percent."

Folck points out that of these 42 million women in the work force, 71 percent are of childbearing age, which portends a possibility of 2 million pregnancies in the work force in any given year (although it's generally considered that this figure may be significantly exaggerated).

A disturbing statistic, however, lies in the fact that approximately 3 million women of childbearing age are employed in industries where exposure to a reproductive hazard may possibly occur. Should these women become pregnant during their employment, it's possible that more complicated decisions on pregnancy disability will have to be made.

Although the subcommittee was reluctant to develop actual guidelines on who was and was not eligible for pregnancy disability, they did see the need for a degree of consistency within the profession in making these decisions and reemphasized some of the basic tenets already established in this area.

Both the American College of Obstetricians and Gynecologists (ACOG) and the National Institute of Occupation Safety and Health (NIOSH), for example, have developed Guidelines on Pregnancy and Work. Some state obstetrical societies have also developed their own guidelines or recommendations in the interest of pregnant employees even though any set of standards cannot supersede individual medical certification.

"The physician must also recognize that the law prescribes equality of treatment, but not equality of benefits."

It is important, however, that physicians be aware of the patient's health status and the specific and well-defined requirements of her work assignment before certifying a medical disability.

The physician would probably do well to inquire directly to the employer for a description of the patient's present work category or any possible new work assignment. The patient usually does not have the right to refuse a new work assignment and so medical opinions about disability should be directed at the patient's capacity to perform available work.

There is agreement by many employers that a policy of permitting the patient to begin pregnancy absence four weeks before delivery and to return six weeks afterwards is reasonable and sensible. It should be emphasized that women must be allowed to work if they so desire until labor begins and to return to work earlier, but preferably with their physician's approval.

The physician must also recognize that the law prescribes equality of treatment, but not equality of benefits. Where the employer has no plan for payments for sick/injury absence, none is required. Where one is present or is instituted, the pregnant employee is entitled to the same benefits as nonpregnant female, or male employees, neither more nor less, under the provisions of the law.

Under the new circumstances, former limits have been expanded. As an example, a company will declare that an employee may leave one month before delivery, and remain away for four, six, eight, or even ten weeks postpartum. This should be clearly understood for what it is — an employment benefit, which has nothing to do with medical judgment and opinion, and will vary widely from company to company. Some employers will allow or even encourage precautionary or optional leaves of absence from work assignments that may have reproductive risks. This problem will probably receive more attention in the 1980s.

In conclusion it would seem that all parties involved in this problem — obstetricians, occupational physicians, and employers — would do well to devise as many ways as possible to disseminate information so that fair medical opinions can be rendered which are not too time consuming for practicing physicians. OSMA

Medicare Coverage in Nursing Homes

By William D. Loeser, M.D., Emil S. Dickstein, M.D., and Leonard D. Schiavone, Esq.

(Reprinted from the New England Journal of Medicine with the permission of the New England Journal of Medicine, and the authors.)

Elderly citizens and their concerned offspring incorrectly assume that Medicare coverage surely makes them eligible for care in a nursing home when the need eventually arises. There is a good reason for this assumption — after all, the Medicare pamphlets distributed by the Department of Health and Human Services (HHS) state that should hospitalization be followed by a need for nursing home care, Medicare can provide up to 100 days of benefits. Although it is clearly stated and generally understood that there are minor impediments to these benefits (eg, a stay of at least three days in a hospital and a period not longer than 14 days between leaving the hospital and entering a skilled nursing facility), a rude awakening awaits most nursing home applicants when they learn that they have been declared ineligible. This surprise occurs because the Medicare Act requires the new nursing home resident to be in need of *skilled* nursing care. The Medicare statute is quite specific about the meaning of "skilled care" and what it entails, differentiating it from "custodial care"; residents in a skilled nursing facility who need custodial care are excluded from Medicare benefits.

Custodial care

Custodial care is indeed the crux of the matter, since residents who require only custodial care in a nursing home are required to pay their own way, yet custodial care has never been specifically defined.

Instead of dealing directly with what custodial care entails, the Medicare establishment has taken the opposite tack by defining what is covered and who will receive coverage by the stricture of need for "skilled nursing care." Skilled nursing care has been defined and redefined through the development of an anthology of manuals and internal memorandums. A clerical hierarchy has arisen, with clerks, nurse specialists, and physician consultants handing down decisions

on who will receive benefits and who will not. It is important to note that the administration of Medicare benefits is performed by insurance carriers, not by the federal government, and that these carriers employ and supervise the clerical hierarchy just mentioned. This decentralization of authority results in marked variations in interpretation of the law; decisions relating to benefits are often arbitrary and unpredictable. An appeals mechanism exists, and it is also arbitrary and unpredictable; the initial appeal is to the same carrier to reconsider the decision, rather than to any impartial regulatory or judicial body. The reason for the overuse of this exclusion appears to us to be cost containment, since vast sums of money are saved when posthospitalization nursing home payments are denied. This policy creates hardship for a segment of society. Whereas the indigent welfare recipient is usually protected through payment of all costs by Medicaid and the wealthy patient can generally afford whatever basic care is needed, the self-paying patient who has conserved his modest resources for illness in advanced years is hard hit by charges of $700 to $1600 a month in today's skilled nursing facility.

The government has given illustrative examples of the situations that require skilled nursing care. A typical noncustodial case involves "an aged patient with diabetes mellitus and angina pectoris recovering from an open reduction of a fracture of the neck of the femur. He requires careful skin care, appropriate medication, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted mobility. . ." The aged and dilapidated anginal diabetic with fewer complications may well be declared to need custodial care and thus to be ineligible for benefits, as indeed might this same patient if his case were reviewed by an intermediary clerk in a neighboring state.

Some of us have stood by helplessly as our patients were denied their anticipated Medicare nursing home benefits. Some patients are denied their "days" altogether, and others are given a specified few days of benefits; eg, 30 days maximum for a fractured hip, nine for pneumonia, 10 for congestive heart failure, and so forth. At present, we know of no single established diagnostic entity deemed to warrant the full 100 days of care that are mentioned in the law. It should be recalled that 10 years ago, before the custodial care exclusion was used to such a major extent, a patient with a fractured hip who was admitted to a nursing home generally was allotted 100 days.

Illuminating cases

Although our efforts have been limited to expressions of frustration, others have not stood by idly. We have found a number of federal court decisions overturning HEW and HHS decrees, and we quote here the highlights of a few illuminating cases.

A 72-year-old woman went from the hospital to a nursing home, where she died five months later with widespread metastatic breast cancer, diabetes mellitus, and emphysema; she could do nothing for herself, and she required a special diet and substantial doses of medications. The courts reversed HEW's ruling that the patient was eligible for custodial care alone. They found that the purpose of the Medicare Act was to ensure adequate medical care to the aged and that the Secretary of HEW was inappropriately using restrictive and unjustified definitions of custodial care, frustrating the purpose of the Act to minimize costs.

One federal court did try to examine the original reasons for the custodial care exclusion and noted the following:

Indeed, it appears to this Court that the purpose of the custodial care disqualification was not to disentitle old,

continued on page 353

A Broken Promise

William D. Loeser, M.D., is an OSMA member, and practices at Heritage Manor in Youngstown, Ohio. Emil S. Dickstein, M.D., an OSMA member, practices with the Youngstown Hospital Association.



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chronically ill and basically helpless, bewildered and confused people from the broad remedy which Congress intended to provide for our senior citizens. Rather, the provision was intended to stop coldblooded and thoughtless relatives from relegating an oldster who could care for him or herself to the care of an ECF (extended care facility) merely so that the oldster would have a place to eat, sleep or watch television. But when a person is sick, especially a helpless old person, and when those who love that person are not skilled enough to take care of that person, Congress has provided a remedy in the Medicare Act, and that remedy should not be eclipsed by an application of the law and findings of fact which are blinded by bureaucratic economics to the purpose of Congress.

How can the inequities that we have discussed be remedied without resorting to case-by-case litigation? The Medicare guidelines could be clarified and simplified without major difficulty. The distinctions between custodial care and skilled nursing care in any particular case are usually discernible by the attending physician. General criteria for this distinction could be defined in easily understood language and placed in the HHS skilled nursing facility manuals. An explanation of this distinction and an honest and clear account of it in the Medicare handbook that is passed out to the public would help to prepare people for the discovery that the new nursing home patient might be paying for his own care.

There would be fewer difficulties if the spirit of the law were more firmly implanted in the statute itself, and for this reason a change in the law might be beneficial. This change would entail a special recognition of the needs of the nursing home resident as opposed to the care that the resident is receiving. Thus, an old, sick, and helpless resident could be more fairly viewed by an insurance intermediary as requiring skilled nursing care, whereas the true custodial patient could be more obviously designated as the less sick and less helpless patient whose basic needs are food, shelter, and a guiding hand.

In this last regard, there is a conflict of interest. How equitably can the insurance carrier judge a situation when all the motivation it has is to deny coverage? The attending physician is not granted the right to decide which residents qualify for Medicare benefits because of the presumed bias in favor of patients who would receive these benefits.

The decisions of carriers are notably variable and arbitrary. It would be fairer to change the present mode of administering this part of the Medicare law, which is based on manuals and memorandums, to a strict regulatory administration. After all, the statutes do specifically require the Secretary of HHS to define posthospitalization extended care services and their costs by regulation.

There will be inevitable conflicts and disagreements. The appeals process could certainly be made more adequate by the use of an independent adjudicating body instead of the current process of appealing to the same insurance carrier, then to HHS, and then to the courts. OSMA

"Some of us have stood by helplessly, as our patients were denied their anticipated Medicare nursing home benefits."

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Stewart B. Dunsker, M.D., assumed the office of president of the Ohio State Medical Association last month, during the Association's Annual Meeting

A profile of OSMA's new president

Stewart B. Dunsker, M.D.:

Sharing a Collective Legacy

By Karen S. Edwards

Anyone entering the office of president of a large association is bound to want to leave behind a footprint — a mark which somehow delineates the personality and leaves an impression of it, not only on the office itself, but in the annals which comprise the association's history.

However, Stewart B. Dunsker, M.D., the Cincinnati neurosurgeon who assumed the office of President of the Ohio State Medical Association (OSMA) last month, thinks of himself as an exception to the rule.

"I'm not sure that wanting to leave your mark — to be remembered for what you accomplished as President — is a legitimate need. One year is a very short time to serve a stewardship in such a large organization. As I see it, the job of any new president is to try to continue the direction, the goals, set by preceding presidents."

Dr. Dunsker does plan to direct his attention to two areas which have not yet been fully addressed by the organization.

He plans to establish a negotiation committee which will explore those needs the OSMA may have in the future in negotiating with insurance companies, government agencies, hospital administration and other such groups — and he hopes to increase the efficiency of the organization by making a concerted effort to streamline its structure.

Still, the OSMA's new president feels that some of his work in office has already been outlined by his predecessors.

"A major membership goal was initiated under Dr. (Robert) Thomas, and his membership chairman, Dr. (Thomas) Morgan. It's a goal I intend to pursue."

But such a goal leads, naturally, to other goals which the new OSMA President also deems important.

"Under Dr. Thomas, the OSMA began a serious move to recruit medical students, and was successful in its campaign. Now, however, we need to determine how those medical students should communicate in our society.

"The wave of the future rides on this group," he continues. "They have new ideas which need to be expressed, and we need to broaden our communication with them. It's no good having 'token members' in an association such as ours. Every member should have a voice."

In fact, if one word were to sum up the work which Dr. Dunsker has outlined for himself this coming year, it would probably boil down to that simple, yet complex word, "communication."

Active in organized medicine since the malpractice crisis of 1974-1975, Dr. Dunsker has become especially sensitive to that word, and the two-way street it paves. In his experience at the local and state levels of organized medicine (he has served as First District Councilor, delegate, and on numerous committees of the OSMA), as well as his experience in his own specialty societies (he is a past President of the Society of University Neurosurgeons), Dr. Dunsker has seen, firsthand, what happens when

communication works — and what happens when it doesn't.

"The OSMA's primary mission, at least as I see it, is to help the patients of this community."

"There's not enough communication between the specialty groups and organized medicine," he says, for one example.

"Differences of opinion between the two continue to crop up, and too often, they go their own separate ways. We need to more closely examine the specialties' representation in our House of Delegates, and more actively seek communication with them."

Again and again, conversations with the new president turn to this strong desire, not only to broaden the fronts of communication, but to use communications as a catalyst for action.

"The OSMA's primary mission, at least as I see it, is to help the patients of this community," he says. "Of course, we offer services to the physician, but if our *patients* don't benefit from the activities of our association, then we're not doing our job."

He cites an increasing need in our society for high-quality medical care, "but how," he asks, "can we as physicians, deliver high-quality medicine and still address the problem of high costs?"

The high-cost problem, as Dr. Dunsker sees it, is one of the thorniest problems facing medicine today.

"We're walking a narrow path in a minefield," he says. "We must be cost-conscious — but dealing with people is totally different from dealing with services," he adds — a factor which the federal government may not always take into account.

"A government planner can now prescribe what tests you can have, without knowing anything else about you," he offers in example.

"People need the benefit of health education. They need physicians who can teach health-care economy while still providing quality medical care."

But at the same time, he adds, these people need physicians who can set standards.

"There are a number of important bills in the legislature now, which are health-related. We need to assemble physicians who will not only put these bills in proper perspective, but who will provide some input into these regulations before they become oppressive."

Dr. Dunsker is quick to praise the association's staff.

"The staff works efficiently. They're talented, bright and dedicated," he says, but he stresses the need for more physician involvement in the association and its activities — physicians who will reach out and communicate; who will help the association realize its long-established as well as newly established goals.

Under the stewardship of Dr. Dunsker, that level of physician involvement (which began with Dr. Thomas' successful membership drive) may eventually reach fruition — or it may simply receive a boost, and be passed to the next president to handle in his or her own way.

However long it might take, the goal will ultimately be reached — thanks to the short, one-year tenures of such physicians as Dr. Dunsker.

That matter of "leaving behind a footprint" may be moot, indeed, for as Dr. Dunsker has already astutely pointed out, *whomever* steps into the shoes of OSMA President leaves behind a collective legacy which is remembered far longer than any single footprint could possibly be. OSMA







When in the U.S. . . . do as the Swedes do!

By Leslie Laine

One hundred a day, eight every half hour, tens of thousands of Swedish women have filed, one-by-one, into a trim, modern mobile van to have their pictures taken. Those pictures may be life-saving.

These women represent the study population of a randomized, prospective clinical trial to test the efficacy of mammography used **alone** to detect early, curable breast cancer. The results, so far, are encouraging to one of the project's directors, Laszlo Tabar, M.D., who presented his preliminary findings this spring to members of the Academy of Medicine of Cincinnati.

"We have found tremendous amounts of small cancers in the early stages," Dr. Tabar said. "This can predict that the end result will be positive: we are going to lower the mortality from breast cancer. And that, of course, will lead us to the conclusion that screening is desirable and should be spread."

Breast Cancer No. 1 Killer

Faced with a rising incidence of breast cancer in Sweden (it is also on the rise in the United States) and an unchanging mortality rate that ranks breast cancer as the leading killer of women 45 to 55 years of age, the Swedish National Board of Health and Welfare decided in 1976 to find a way to attack the problem.

"It has been proven in the past decades that even if we develop new therapeutic methods — radical or super-radical surgery, in combination or without radiotherapy, for example — "it just couldn't change the mortality rate for breast cancer," Dr. Tabar explained. "So there is one thing left: to find the cancer sooner."

The method chosen had to be efficient, not expensive to administer to thousands of women, with a high sensitivity and specificity, and it had to be acceptable to women. Film-screen mammography was selected and a program was set up to study its efficacy in a controlled, national clinical trial.

As it is designed and operating, the Swedish trial is different in two respects from previous breast cancer studies done in the United States. Earlier samplings have investigated the effectiveness of mammography used in conjunction with physical examinations; this trial uses mammography alone. In addition, the Swedish plan is a true controlled experiment in that an informed, consenting control group is participating.

In all, 161,000 women over the age of 39 were recruited for the project: 94,000 in the study group and 67,000 in the control population. The study sample would receive mammography screening several times before the project's termination around 1983 while the control group would not be screened at all.

Because the two counties chosen for the trial are sparsely populated (nine to ten people per square kilometer), the Board equipped a mobile van with a dedicated mammography unit and arranged for the van to go to the women, rather than vice versa. The exposed films would be sent to the Mammography Department at Falun Central Hospital in Falun, Sweden, where Dr. Tabar is chief of that division.

The Work Plan

The van visits various areas of each county at predetermined intervals. Of 120 women invited to each day's screening, approximately 100 respond. Those women, stripped to the waist, approach the mammography unit, and with the help of an assistant, situate a breast, one at a time, against a clear plastic plate. The assistant then operates a foot pedal to bring the plastic plate against the film plate, compressing the breast in between.



Leslie Laine is the Director of Communications for the Academy of Medicine of Cincinnati

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Women whose films are judged normal receive notification within two or three days. However, if the screening center radiologist notes or suspects lesions, the woman is called back for further examination. "That includes a complete mammography clinical examination, biopsy, anything to make diagnosis of the discovered lesion," Dr. Tabar said.

Women in the control group who may find a lump in their breasts through self-examination may not go to the screening center for mammography. Instead, they are directed to the hospital for a thorough examination. If the attending physician orders mammography, or any other diagnostic procedure, the woman receives it.

Encouraging Results

Since the trial began in October, 1977, 92.5% of the study population, (or 90,000 women), has been screened at least once. A second round of screening for the youngest age group began in June 1980.

Preliminary data from the first round indicate many more small, curable cancers are being detected in the study population than in the control group. While the incidence of medium-sized lesions (11-20 mm) is similar, the number of smaller tumors in the study group outnumbers the control by nearly four to one.

The discovery of breast cancer at its earliest development pays off not only because the tumors are smaller, but also because the involvement of the lymph nodes at that stage is greatly reduced. "The smaller the cancer, the less chance there is that it has spread," Dr. Tabar pointed out. "We find the lymph nodes in the small cancers of the study group have no metastasis, or at least not to the extent we find in the control population."

What Next?

While it is too early, Dr. Tabar believes, to predict the outcome of this clinical trial on breast cancer mortality rates, he finds the preliminary data very promising for the detection of early breast cancers and sees it as strong evidence to support more widespread use of mammography as a detection tool.

Still, admitting that "what we are after is mortality," Dr. Tabar says, "Now we are going to follow up with both of the populations and see how many women are going to die of their breast cancer in the control population as compared with the study population. This follow-up will be a very thorough job. All data we collect will be entered into a computer and what we are after is the quality of life of a breast cancer patient as well as mortality data." OSMA



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"Medicamentosis" is alive and well . . .



The Saga of One Man's Medicine Chest

By Karen S. Edwards

Editor's Note: *Following close on the heels of the special May Journal on drugs came the 26th Annual Ohio Pharmaceutical Seminar, a three-day barrage of pharmaceutical information intended of course, for pharmacists, but applicable to all health-care professionals.*

While a number of stories seemed to lie in wait behind each speaker's address, the one that sprang to immediate attention was the one hidden within the text of a speech entitled "Uncommon Clinical Problems of Drug Therapy: A Close Study," delivered by George E. Francisco, Jr., an assistant professor of clinical pharmacy at the University of Georgia.

The reason that this story seemed to need retelling is because it echoes, in more specific detail, those very "Prescribing Problems" which George D. Clouse, M.D., a Columbus family practitioner, had chosen to write about in the May Journal.

In his article, Dr. Clouse profiled the "overmedicated" patient: the "Loyalists," the "Hoarders," and the "Pseudo-Pharmacists" who acquire a stockpile of drugs that would rival the corner drugstore. If anyone read this article, and still holds doubts that those patients are out there, read on. Francisco's remarkable case study may be just what you need to change your mind.

"W.S.," as the patient was referred to throughout the discussion, is a 65-year old white male who was being monitored by a local Home Health Care Department for the following problems:

1. Degenerative joint disease, which had only appeared within the last two years.

2. Hypertension, again a problem which had only occurred within the past two years.

3. Asthma with chronic bronchitis.

On the first visit to the home of "W.S.," the following medications were found: Indocin; Escot; Dicarbosil; Maalox; Papaverine; Phazyme; Periactin; Tetracycline; Nitroglycerine; Peritrate SA-80; Hydrocortisone cream; Hygroton; Lasix; Sudafed; Ornade; Doxidan; Valium; Unicap M; Anacin; Tylenol; Arthritis strength bufferin; Darvocet N-100; Darvon Compound 65; Aminophylline; Aldomet.

The last two medications listed were only on prescription blanks, and had not actually been filled. The reason —

perhaps more shocking than the list, itself — was that W.S. was ineligible for Medicaid, and so he was footing the payment for these drugs himself. Apparently his income couldn't quite cover the payment for the last two medications prescribed, so they remained unfilled.

But how did this whole scenario happen? How could such a stockpile of drugs accumulate within a short, two-year period? Actually, it all began quite innocently.

Indocin had been prescribed to the patient for his rheumatoid arthritis — certainly a legitimate pharmaceutical aid for the problem. However, both the physician and the pharmacist had neglected to tell the patient that the drug was to be taken with food, or at least water, and so a basic lack of communication led W.S. on to the next three drugs in his medicine chest: **Escot, Dicarbosil** and **Maalox** ("Prescribed by a friendly pharmacist") — all antacids for relief from the stomach distress he suffered from taking Indocin without the requisite food and/or water.

"Now," Francisco points out, "as we all know, Indocin is structurally related to LSD, and can give similar hallucinatory side effects."

W.S., indeed, was suffering from auditory hallucinations, a fact which deeply concerned W.S.'s daughter. She pressed the physician for something to ease the hallucinations and so **Papaverine** was prescribed.

W.S., now consuming five pills a day, experienced a lack of appetite — another fact which did not slip past the family. Again, W.S.'s daughter took her concerns to the physician, and left at one point or another in time with prescriptions for two appetite stimulants: **Phazyme** and **Periactin.**

Tetracycline had been prescribed to help the patient's bout with chronic bronchitis.

"The dose, however," Francisco said, "was an unusual one. He was taking the drug anywhere from one to four times a day during the first ten days of the month. Sort of like birth control pills," he quipped. Certainly such a dose did not lend itself well to patient compliance, and perhaps because of missed pills — or too many pills — the stomach distress came back.



George E. Francisco, Jr., Assistant Professor of Clinical Pharmacy at the University of Georgia, spins an incredible true-story tale at the 26th Annual Ohio Pharmaceutical Seminar.

"Darvocet N-100 and Darvon Compound 65 were prescribed for W.S.'s arthritic pain, but friends recommended both Anacin and Tylenol for the problem, so W.S. bought them over the counter."

This time, the physician thought the distress might possibly signify some anginal problem. That's why **Nitrogylcerine** and **Peritrate SA-80** found its way into the patient's stockpile.

Hydrocortisone cream had been prescribed for a problem which the patient had had during the summer with poison ivy. However, a neighbor had told W.S. that the cream helped to diminish those "ugly brown aging spots," so the patient continued its use, long after the poison ivy rash had cleared.

Hygrotin had been prescribed for W.S.'s hypertension, but when the physician changed to another drug for hypertension, **Lasix**, no one remembered to tell W.S. to discontinue the Hygrotin. So he continued taking both.

Because of his daily dose of antacids, W.S. was now having trouble with constipation, so **Doxidan** was prescribed.

"And because no drug regimen is complete without **Valium**," Francisco said, "W.S. was taking two valiums every day."

W.S.'s daughter, still concerned over her father's lack of appetite (though oddly enough never questioning it) bought him some **Unicap M's**, just to make sure his nutritious needs were being met.

Darvocet N-100 and **Darvon Compound 65** were prescribed for W.S.'s arthritic pain, but friends recommended both **Anacin** and **Tylenol** for the problem, so W.S. bought them over the counter. In the meantime, those television commercials for **Arthritis Strength Bufferin** depicted a pain-free existence that just looked too good not to be true, so W.S. added them to his arsenal as well.

If nothing else, Francisco's "saga" should add its own stamp of validity to the picture which Dr. Clouse painted in the May *Journal*.

"Medicamentosis," as Dr. Clouse colorfully coined it, is a very real problem, and the reasons for its existence are as varied as they are numerous. Miscommunication, family pressure, and bad advice are just a few of the contributors which make drug abuse at home as much a problem as it is in the streets.

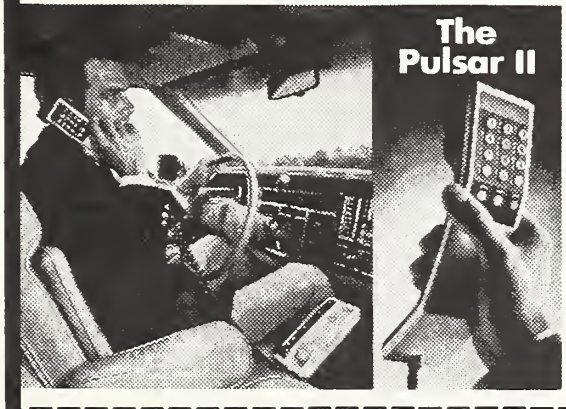
One optimistic stroke, however, is that physicians and pharmacists both are becoming aware of the problem, and are making each other aware.

"There's no doubt that the physician is going to have to assume a more active role in health education in the future," said Joseph R. Bianchine, M.D., professor of pharmacology at Ohio State University, during an interview last April. "Every time he hands the patient a prescription, he's going to have to offer an explanation along with it."

"Pharmacists are going to have to educate patients about drug usage," Francisco said, reiterating the theme before the 200-plus pharmacists assembled at the seminar.

With such education coming from both physician and pharmacist, the patient with "medicamentosis" may finally relegate that unnecessary stockpile of pills and drugs down the drainpipes where they belong. OSMA

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Claims Trends Mandate Rate Adjustments

(Effective June 1)

Physicians Insurance Company of Ohio, formed by the OSMA during the height of the medical professional liability crisis of the mid-'70s, has announced its second rate adjustment during its four and one half years of business.

The first adjustment, in October 1979, reduced rates. This adjustment, effective June 1, 1981, results in an increase of approximately 25% for all physicians in all parts of Ohio. With this adjustment, rates return to approximately the 1976 level.

Queried as to the reason for this June 1 adjustment, Joseph K. Gilmore, president of PICO since its formation, said: "The reason is that while the availability part of the mid-'70s crisis has been resolved, at least temporarily, the basic causes of the crisis are still with us. Those causes are rising claims frequency and severity."

Gilmore added: "Claims experience and trends during 1976-1978 proved to be better than anticipated, permitting the rate decrease in 1979. Conversely, claims trends during 1979-1980 and to date in 1981 have proven to be worse than anticipated, thus a rate increase is now indicated."

Gilmore described the present claims trends situation as national in scope and noted that many of the more than 25 physician-owned insurance organizations formed since 1975 have taken or are planning to take rate increases. Other major insurers also have initiated upward rate adjustments. Gilmore cited specifically St. Paul, which remains the largest national writer of medical professional liability insurance (and offers only claims-made coverage), which has significantly increased rates in most states this year; and rate increases by physician-owned companies in Tennessee, Florida, California, New York, and Illinois.

PICO has processed more than 1,400 claims since the beginning of business, of which more than 800 remain unsettled. During 1979, nearly 500 claims were reported and an additional 700 claims were added to the files in 1980.

Rating mechanisms for medical professional liability insurance are more complex than for other forms of liability insurance, primarily because of the long tail nature of claims. Claims may not be reported for several years following the actual occurrence date and may not be settled for several more years, due to protracted litigation procedures. Claims trends become a most significant and important measurement, since an upward swing in number of claims actually reported signals an accompanying upward trend in the number of as yet unreported claims that will surface in future years. Unless insurers prepare appropriately for these future claims, by establishing rates based on trends as well as actual calendar year experience, they face the real probability of inadequate reserves for future loss experience.

The history of medical professional liability insurance is strewn with the names of both large and small companies that failed to properly note and prepare for the long tail of claims during periods of rising frequency and severity. Unfortunately, the policyholders actually paid the price, in the form of extreme rate adjustments or surcharges, or worse, by no longer having a source of protection.

PICO also believes that a major key to long-term success in this volatile form of insurance protection is adequate claims reserves.

Reserves, as well as rates, must reflect the long tail nature of claims. Thus, reserves for a given policy year must reflect not only actual claims reported, but unreported claims based on analysis of claims trends for as long as 14 years. As a company continues in business, this becomes a cumulative procedure, ie, each year additional

(continued on page 380)

"While the availability part of the mid-'70s crisis has been resolved, at least temporarily, the basic causes of the crisis are still with us. Those causes are rising claims frequency and severity."

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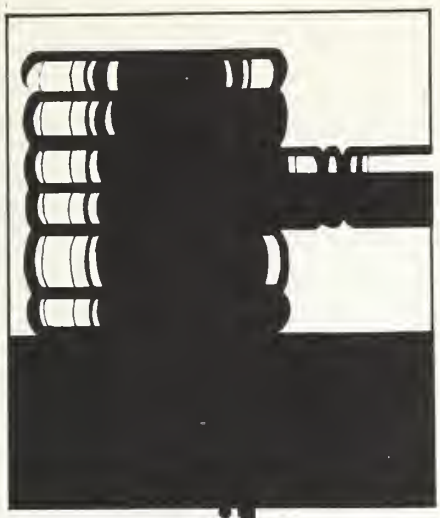
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council proceedings

PROCEEDINGS OF THE COUNCIL

March 7, 1981

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, March 7, 1981, at the Hyatt-Regency Columbus, 350 N. High Street, Columbus, Ohio.

Those present were: Robert G. Thomas, M.D., Elyria; Stewart B. Dunsker, M.D., Cincinnati; Thomas W. Morgan, M.D., Gallipolis; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; C. Douglass Ford, M.D., Toledo; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; William Dorner, Jr., M.D., Akron; John H. Budd, M.D., Cleveland; W. J. Lewis, M.D., Dayton; Oscar W. Clarke, M.D., Gallipolis; John J. Gaughan, M.D., Cleveland; Jerry L. Hammon, M.D., Dayton; Robert N. Smith, M.D., Toledo; Theodore J. Castele, M.D., Cleveland; Edward E. Grable, M.D., Canton; Charles L. Hudson, M.D., Bratenahl; Lawrence J. McCormack, M.D., Cleveland; William H. Gates, M.D., Cincinnati; John H. Ackerman, M.D., Columbus; James E. Pohlman, Esq., Columbus; and Joseph K. Gilmore, Pickerington.

Those present from the OSMA staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Robert E. Holcomb; Gail E. Dodson; Richard A. Ayish; Rebecca J. Doll; David C. Torrens; Carol W. Mullinax; David W. Pennington; Eric Burkland; Michael L. Bateson; Jennifer M. O'Brien; and Lou Saslaw.

ANNOUNCEMENTS BY PRESIDENT THOMAS

President Thomas read a letter from the Academy of Medicine of Toledo and Lucas County announcing the candidacy of C. Douglass Ford, M.D., for President-Elect of the Ohio State Medical Association.

Dr. Thomas announced that there will be an opening this month on the Ohio State Medical Board.

The Council voted to support the following candidates for the board position: Dr. William T. Collins, Lima; Dr. Alford C. Diller, Van Wert; Dr. A. Burney Huff, Wooster; and Dr. Carl E. Spragg, New Concord.

ADMINISTRATION

The minutes of the January 24, 1981 meeting of the Council **were approved.**

In response to a request from the Meigs County Medical Society and from Veterans Memorial Hospital, Dr. Frank L. Shively of Dayton, was designated to serve on an impartial board of physicians to investigate and arbitrate a matter involving staff privileges at the hospital.

Ohio Medical Political Action Committee — It was voted that the OSMA Council, on an annual basis at the OSMA Council meeting prior to the meeting of OMPAC at which members of the Board are elected, recommend individuals for consideration as members of the OMPAC Board.

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Treasurer's Report — Dr. Barr presented the report of the Treasurer. The report was received for information.

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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
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Membership Statistics — Membership statistics were presented by Mrs. Wisse, who reported on details of the current membership campaign.

Committee on Membership — Dr. Morgan presented the minutes of the February 25, 1981 meeting of the Committee on Membership.

The Council considered a recommendation of the Committee that amendments to the Association's Constitution and Bylaws in the form of an appropriate resolution embodying the establishment of an OSMA medical student section be submitted by the Council to the OSMA House of Delegates at the 1981 Annual Meeting with background and explanatory information. The recommendation was **approved.**

Committee on Auditing and Appropriations — Dr. Ford presented a recommendation from the Committee on Auditing and Appropriations to appropriate $500 to cover Dr. Perry R. Ayres' expense to the 12th Annual NCA/AMSA/RSA Medical-Scientific Conference on Program in Alcoholism Research and Treatment. Dr. Ayres will participate as chairman of the OSMA Physician Effectiveness Program.

Dr. Ford reported that computer firms will be requested to look at requirements for tape-to-tape data entry and be asked to submit specification and bids for a pilot program.

DEPARTMENT OF EDUCATION & MEETING MANAGEMENT

Committee on Emergency and Disaster Medical Care — Dr. Gates reported on the OSMA-OHA Conference on Categorization of Hospital Emergency Capabilities held February 11 and 12, 1981.

He announced that a more formal report of the Committee will be presented at a later date.

The Committee will meet April 1, 1981 to formalize a report.

It was agreed that the report of the Committee be sent direct to the House of Delegates prior to review by the Council.

Ad Hoc Committee on Evaluation of Interim Meetings — Dr. Dunsker presented the minutes of the March 6, 1981 Ad Hoc Committee on Evaluation of Interim Meetings.

The Council **approved** for forwarding to the House of Delegates the Committee's recommendation that regular interim sessions of the House of Delegates not be held by the Ohio State Medical Association.

The Committee recommended that the Annual Update Meeting in its present form be discontinued due to lack of interest. The Council **approved** the recommendation for forwarding to the House.

He reported that the Committee continues to discuss other forms of communications and meetings and will report later.

Dr. Dunsker announced that background data on annual meeting structures and costs have been prepared by the Committee and Council authorized their inclusion in the report to the House.

OSMA Annual Meetings — The Council voted to request that the OSMA Annual Meeting be opened with the presentation of the National and State flags by a Color Guard.

DEPARTMENT OF GOVERNMENT RELATIONS

Health Planning Update — The Health Planning Update was presented by Mr. Pennington.

Regionalization — The term "Regionalization" and its meanings were discussed briefly.

Ad Hoc Committee on Incentive/Disincentive Programs — Dr. Abromowitz reported on the February 13, 1981 meeting of the Ad Hoc Committee on Incentive/Disincentive Programs.

Communication from Dr. Kose — The Council studied a letter from Dr. William Kose, Findlay, Ohio, concerning the position of the OSMA concerning Professional Standards Review Organizations.

Dr. Oscar W. Clarke commented on the matter with regard to the action of the AMA Delegation, which, it was pointed out, was in accordance with the policies of the OSMA House of Delegates.

Dr. Thomas was authorized to reply to Dr. Kose.

The PSRO issue was referred to an Ad Hoc Task Force to be appointed by the President for the development of a policy statement clarifying the position of the Ohio State Medical Association with regard to professional peer review and to develop a method to fulfill organized medicine's obligations for professional peer review.

DEPARTMENT OF ORGANIZATION SERVICES

AMA Delegation — Dr. Clarke announced the election of Dr. Clarke as chairman of the AMA Delegation for the coming year and Dr. Smith as vice-chairman. This election was confirmed by the Council. The President of the OSMA serves as co-chairman of the Delegation by reason of his office.

Dr. Lawrence McCormack, President of the College of American Pathologists, was introduced, and briefly addressed the Council.

Dr. W. Jack Lewis, member of the AMA Board of Trustees, reviewed some of the current issues before the Board and also discussed the June meeting of the AMA House of Delegates.

Task Force on Professional Liability — Mr. Campbell presented the minutes of the February 10, 1981 meeting of the Task Force on Professional Liability. The Council received the minutes for information.

DEPARTMENT OF HEALTH EDUCATION

Joint Advisory Committee on Sports Medicine — Mr. Clinger presented the minutes of the January 17 and 18, 1981 meeting of the Joint Advisory Committee on Sports Medicine and they **were approved.**

OSMA/ONA Liaison Committee — Mr. Clinger presented the minutes of the January 21, 1981 meeting of the OSMA/ONA Liaison Committee.

DEPARTMENT OF FEDERAL AND STATE LEGISLATION

Joint Underwriting Association — Mr. Pohlman presented a memorandum from legal counsel with regard to legislative alternatives for termination of the Joint Underwriting Association (JUA).

It was voted that the matter be referred to the Committee on Legislation, with a request that the matter be addressed and a recommendation be brought back to Council as soon as possible.

State Legislative Committee — Dr. Payne reported on activities of the State Legislative Committee.

Federal Legislation — A Federal Legislative Update was presented by Mr. Mulgrew. He announced certain federal budget cuts and referred the Council to the AMA Legislative Bulletin.

He announced that Rep. Thomas Luken, Cincinnati, is introducing a bill in Congress to modify the Federal Trade Commission's authority over professional people.

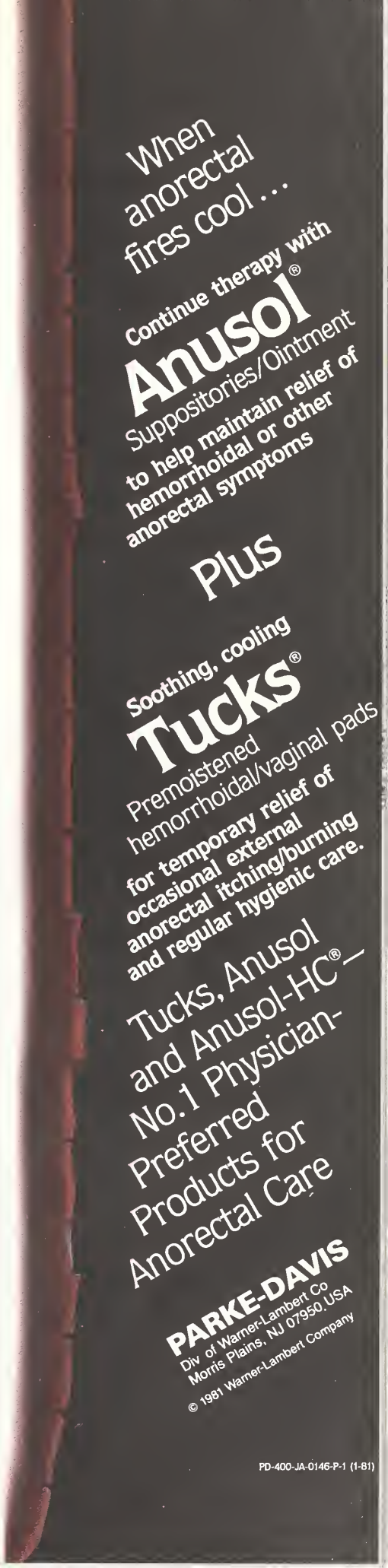
State Legislation — Mr. Ayish presented the State Legislative Report and reviewed a number of proposals which will be reviewed by the Legislative Committee at its next meeting.

The Council received the minutes of the February 4, 1981 meeting of the Committee on State Legislation for information.

Ad Hoc Committee on Association Structure — Dr. Dunsker presented the minutes of the February 28, 1981 meeting of the Ad Hoc Committee on Association Structure.

The Council **approved** the following recommendations of the Committee:

That the Committees on Laboratory Medicine, Rehabilitation, and Eye Care



not be re-appointed and that their legislative duties be assumed by the Legislative Committee; that the Federal Legislative Committee be eliminated; and that the Workers' Compensation Committee be dissolved and its duties assumed by the Committee on Government Medical Care Programs.

DEPARTMENT OF COMMUNICATIONS

Synergy — Ms. Mullinax reported that "Synergy" is now being distributed to its members by the Maine Medical Society.

Committee on Communications — Ms. Doll reported on a February 18, 1981 meeting of the Committee on Communications. Ms. Doll stated that the Committee will meet regularly and that a more formal report will be submitted at the next meeting.

DEPARTMENT OF FIELD SERVICE

Mr. Holcomb introduced Mr. Louis Saslaw, his new associate in the Field Service, who addressed the Council briefly.

Mr. Holcomb reported on issues being discussed by county medical societies.

CONSTITUTION & BYLAWS

Amendments to the Constitution and Bylaws of the Miami County Medical Society and the Guernsey County Medical Society were approved.

LEGAL COUNSEL REPORTS

Mr. Pohlman presented the report of the legal counsel.

OHIO DEPARTMENT OF HEALTH

Dr. John H. Ackerman, Ohio Director of Health, addressed the Council on matters of public health and preventive medicine.

AUXILIARY BYLAWS

The informal approval on February 13, 1981, of amendments to the Ohio State Medical Association Auxiliary Bylaws was ratified and affirmed by official action of the Council.

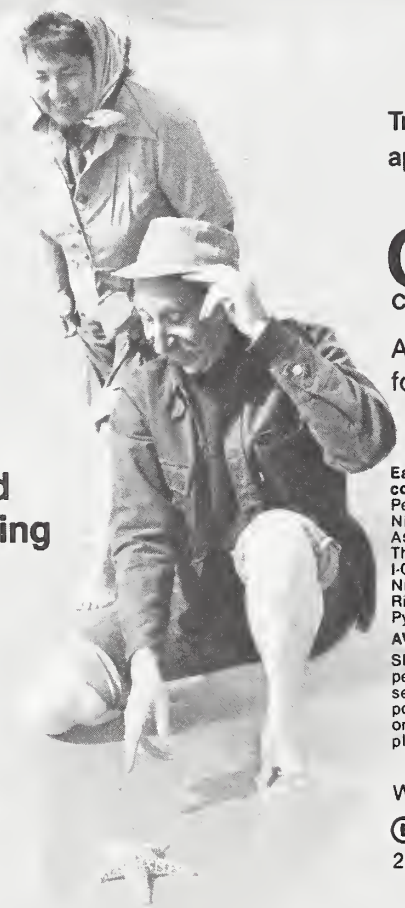
COMMUNICATION FROM KENT LOUIS BROWN, M.D.

Dr. Morgan brought to the attention of the Council a letter from Dr. Kent Louis Brown, of Cleveland.

ADJOURNMENT

There being no additional items of new business or old business, the meeting was adjourned. The next meeting of the Council is scheduled for May 2, 1981.

ATTEST: Hart F. Page, CAE
Executive Director



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Treat the symptoms in the geriatric patient... apathy, irritability, forgetfulness and confusion

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Each CEREBRO-NICIN® capsule contains:

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Niacinamide	5 mg.
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Pyridoxine HCL	3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

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WARNING: Overdosage may cause muscle tremor and convulsions.

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BUTLER
Mary Ellen Gaeke, Middletown
Richard F. Gaeke, Middletown
Marcus P. Oswald, Hamilton
Rahib N. Vasi, Fairfield
William G. Weathers, Hamilton

CUYAHOGA (Cleveland unless noted)
Ashok W. Argekar
Ronald Allen Bailey
Joseph A. Boccia
Wilfred J. Brownlow, Jr.
Victor A. Ceicys
Neal C. Chadwick
Robert B. Daroff
Muhammad S. Farooqi
Michael H. Frankel
Richard B. Freeman
Sharon F. Grundfest
Elizabeth B. Hill
Andrew Jimerson
Robert Kay
Victoria A. Langsam
Daniel J. Mazanec
Marcello Mellino
Shailesh R. Nanavati
Bhupendra P. Patel
Arthur Porter
Richard S. Prager
Nuruddin J. Presswala
Robert E. Reaven
Seyed A. Baghery
Jerry M. Shuck
Laszlo S. Tomaschek
Patricia S. Wirtz

LAKE
Iraj Derakhshan, Willoughby
William Krug, Euclid

LORAIN
David W. Kent, Vermilion
Ihor Krynycky, Elyria
Fredrick May, Vermilion

LUCAS
Frederic H. Mattes, Maumee
Paul P. Rega, Toledo
Kytja K. S. Voeller, Toledo

MAHONING (Youngstown unless noted)
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Ernesto V. Angtuaco
Joaquin Corbera
Morris H. Drucker
A. James Giannini
Larry Richardson
Oscar Trujillo
Jose Vidal

MIAMI
Yang G. Chen, Piqua
S. W. Lee, Troy

MONTGOMERY
Martin J. Schear, Dayton

MUSKINGUM
Dinish Patel, Zanesville

PORTAGE
John David Reid, Mantua

STARK (Canton unless noted)
C. Chiu
C. Curtiss
J. Raftery, North Canton
B. Stewart

SUMMIT (Akron unless noted)
A. Abu-Maraq, Barberton
M. Al-Madani, Uniontown
Robert A. Baranek
Gerald Blandford
Calvin Brown
Neal Evan Holleran
Michael J. Hovan
Paul Korytkowski
Kenneth Kretchmer
Carolee Luecken
Chris Marquart
Ghulan N. Mir, Barberton
Pratibha Parikh, Cuyahoga Falls
Peter R. Ricci
Michael Roth
Allan Jay Sandel
Ohiort G. Scarcella
Robert J. Shalowitz
Dorothy Siddall
George M. Solan, Northfield
Frederick Specht
Thomas L. Stover
George S. Toufexis

WILLIAMS (Bryan unless noted)
Edward J. Crouse
Wayne J. Daum
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Worth Quoting

"Suddenly Washington is teeming with people who direct, organize, staff, administer, research and represent various government programs. Each day their rhetoric grows more shrill and their message more ominous. Each evening the TV news programs broadcast their heartbreaking scenes of distress. By now it seems clear; without their services, the poor will not survive.

It's enough to conjure up visions of an economic Armageddon, until we remember a few facts. First, the total size of the spending reductions being proposed amount to approximately 2% of the current fiscal year budget, and less than 7% of the next. . .hardly the kind of cuts that spell catastrophe. Second, for the most part the cuts represent mere reductions in planned spending increases, rather than actual reductions below the level of last year's budget. Third, several programs comprising about 36% of the budget, those that form the so-called safety net under which no poor person must be allowed to fall, have been left untouched. Fourth, much of what is often casually described as social spending does not even assist the poor, but consists of entitlement benefits or subsidies parcelled out to various middle class groups.

Nevertheless, this information is being submerged as the screams of protest from special pleaders grow louder and louder."

Pres. Richard L. Lesher,
from Association Trends,
April 10, 1981

Obituaries



DUDLEY H. BEAUMONT, M.D., Wellsville; Jefferson Medical College, Thomas Jefferson University, 1920; age 96; died February 17, 1981; member OSMA and AMA.

ARTHUR R. COHEN, M.D., Columbus; Ohio State University College of Medicine, 1935; age 73; died February 19, 1981; member OSMA and AMA.

CHRISTIAN DeWINTER, M.D., Akron; Cornell University Medical School, New York, 1948; age 61; died February 17, 1981; member OSMA and AMA.

PAUL DeWITT, M.D., Ravenna; Medical College of Georgia, Augusta, 1948; age 60; died March 12, 1981; member OSMA and AMA.

JOSEPH M. FELKER, M.D., Cleveland; St. Louis University School of Medicine; age 37; died March 20, 1981; member OSMA and AMA.

PAUL O. FUNK, M.D., Cleveland; Johann-Wolfgang Goethe University, Hessen, Germany, 1949; age 63; died February 22, 1981; member OSMA and AMA.

THEODORE GERLINGER, M.D., Cuyahoga Falls; Ohio State University College of Medicine, 1935; age 69; died March 21, 1980; member OSMA and AMA.

EVERETT A. IRISH, M.D., Akron; Western Reserve University School of Medicine, 1927; age 79; died May 24, 1980; member OSMA and AMA.

LOUIS B. KATZ, M.D., Sarasota, Florida; St. Louis University School of Medicine, 1937; age 68; died February 26, 1981; member OSMA and AMA.

WILLIAM W. MARKLEY, M.D., Austin, Texas; Case Western University School of Medicine, 1938; died March 13, 1981; member OSMA.

CHARLES W. MATTHEWS, M.D., Scottsdale, Arizona; Eclectic Medical College, Cincinnati, 1937; age 69; died December 15, 1980; member OSMA and AMA.

NICHOLAS PARADISE, M.D., Cleveland; St. Louis University School of Medicine, 1948; age 62; died March 20, 1981.

JOSEPH J. PODESTA, M.D., Cincinnati; University of Cincinnati College of Medicine, 1939; age 67; died March 7, 1981; member OSMA and AMA.

WILLIAM S. QUIGLEY, M.D., Cambridge; Boston University School of Medicine, 1961; age 49; died March 7, 1981; member OSMA and AMA.

RALPH K. RAMSAYER, M.D., Canton; Case Western University School of Medicine, 1922; age 82; died March 12, 1981; member OSMA and AMA.

JOSEPH B. REILLY, M.D., Akron; Hahnemann Medical College of Philadelphia, 1942; age 67; died December 16, 1980; member OSMA and AMA.

ROBERT P. SCOTT, M.D., Ft. Pierce, Florida; Loyola University Stritch School of Medicine, 1938; age 71; died December 31, 1980; member OSMA and AMA.

PAUL SHAUGHNESSY, M.D., Cleveland; Creighton University School of Medicine, 1930; age 80; died February 28, 1981; member OSMA and AMA.

JOHN J. SHEA, M.D., Dayton; St. Louis University School of Medicine, 1935; age 75; died March, 1981; member OSMA and AMA.

JOSEPH B. STOCKLEN, M.D., Cleveland; Case Western Reserve School of Medicine, 1930; age 75; died March 4, 1981; member OSMA and AMA.

RUPERT B. TURNBULL, M.D., Golefa, California; McGill University Faculty Medical College, Montreal, Quebec, 1940; age 68; died February 21; member OSMA and AMA.

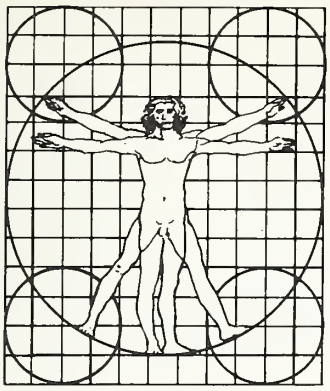
ALBERT WASSERSTEIN, M.D., Akron; University of Poland, 1948; age 74; died October 20, 1980; member OSMA and AMA.

GEORGE R. WELLWOOD, M.D., Barberton; University of Toronto, 1923; age 87; died May 28, 1980; member OSMA and AMA.

ELMER J. WENAAS, M.D., Sarasota, Florida; George Washington University School of Medicine, 1924; age 81; died March 6, 1981; member OSMA and AMA.

THEODORE H. WILL, M.D., Minster; Loyola University Stritch School of Medicine, 1930; age 79; died February 20, 1981; member OSMA and AMA.

REX H. WILSON, M.D., Akron; Ohio State University College of Medicine, 1935; age 72; died February 24, 1981; member OSMA and AMA.



CLINICAL & SCIENTIFIC

THE RESULTS OF CLEAN INTERMITTENT CATHETERIZATION ON THE ABNORMAL UPPER URINARY TRACTS OF CHILDREN WITH MYELOMENINGOCELE

K. Kenney Crooks, M.D.
Benedicta G. Enrile, M.D.
Henry A. Wise, M.D.

Thirty-nine children with myelomeningocele and deteriorating upper urinary tracts were begun on clean intermittent catheterization of their bladders. In 15 patients the hydronephrosis improved; 18 remained stable although ureteral dilation persisted; and in six, progressive hydronephrosis developed. Chronic bacilluria was common, but in the absence of ureterovesical reflux, pyelonephritis was rare. CIC is a safe and effective method of managing the child with a neurogenic bladder.

CLEAN INTERMITTENT CATHETERIZATION (CIC) was popularized in the United States by Lapides.[1] Its use has been expanded to children with neurogenic bladders[2-5] because of the ease and safety of clean technic.

During the past four years, we have used CIC in 70 children with myelodysplasia and abnormal bladder function. In 31 patients, catheterization was begun primarily for urinary incontinence. In these individuals the upper urinary tracts have remained normal. CIC was instituted in the remaining 39 patients because of a deterioration of the collecting system manifested by ureteral dilation and/or loss of renal parenchyma. The results of intermittent catheterization in this select group of patients are reported.

Patient Population and Methods

A total of 265 patients are followed actively in the myelomeningocele clinic. Seventy children with incomplete voiding have been managed by intermittent catheterization for a minimum of six months. The indication for CIC in 39 patients (10 male, 29 female) was an abnormal intravenous pyelogram with hydroureter and/or hydronephrosis. Twenty-two of these children were less than four years old and six were neonates when CIC was started.

Catheterization was initiated usually on a four- to six-hour schedule, however, evening sleep was not disturbed. The frequency of CIC ultimately was determined by bladder volumes and clinical response. Parents or patients were instructed in clean technic, usually as an outpatient, during one to two sessions. Bladder cultures were obtained by sterile technic at three-month intervals. Follow-up intravenous pyelograms were done six to twelve months after CIC was started. In eight children, an anticholinergic agent (usually oxybutynin chloride or propantheline bromide) was added to diminish intravesical pressure.

Results (See Table)

After beginning CIC, ureteral dilation improved in 15 patients (see figure). In 18, the abnormalities of the upper urinary tract have stabilized although ureteral dilation persists. In the remaining six children, CIC failed to prevent progressive renal deterioration. Four of these patients had severe vesicoureteral reflux and subsequently were managed as follows: one by ureteral reimplantation; two by cutaneous vesicostomy; and one by cutaneous ureterostomy. The other two patients have ureterovesical obstruction secondary to severe bladder trabeculation and hypertonicity. An anticholinergic agent recently has been added to diminish bladder tone, however, both probably will require urinary diversion in the future.

From the Department of Surgery (Urology) and Pediatrics, Ohio State University, and the Department of Surgery (Urology), Children's Hospital, Columbus, Ohio.
Dr. Crooks, Columbus, Pediatric Urologist, Children's Hospital; and Attending Staff, University Hospitals.
Dr. Enrile, Worthington, Director of Myelomeningocele Clinic, Children's Hospital.
Dr. Wise, Columbus, Associate Professor of Surgery, and Director, Division of Urology, Ohio State University.
Submitted October 21, 1980.

Status of Upper Urinary Tract

Intravenous Pyelogram

	Before CIC	After CIC		
		unchanged	*improved*	*deteriorated*
Normal	25	25		
Abnormal	39	18	15	6

Chronic or persistent bacteruria occurred in most patients (33/39), however, febrile urinary infections were uncommon in the absence of vesicoureteral reflux. In these patients chronic antibiotic suppression did not appear helpful and its use tended to select unfavorable organisms on subsequent cultures. In the children with reflux, prophylactic antibiotics were beneficial in reducing the frequency of pyelonephritis. Traumatic complications related to catheterization were not observed.

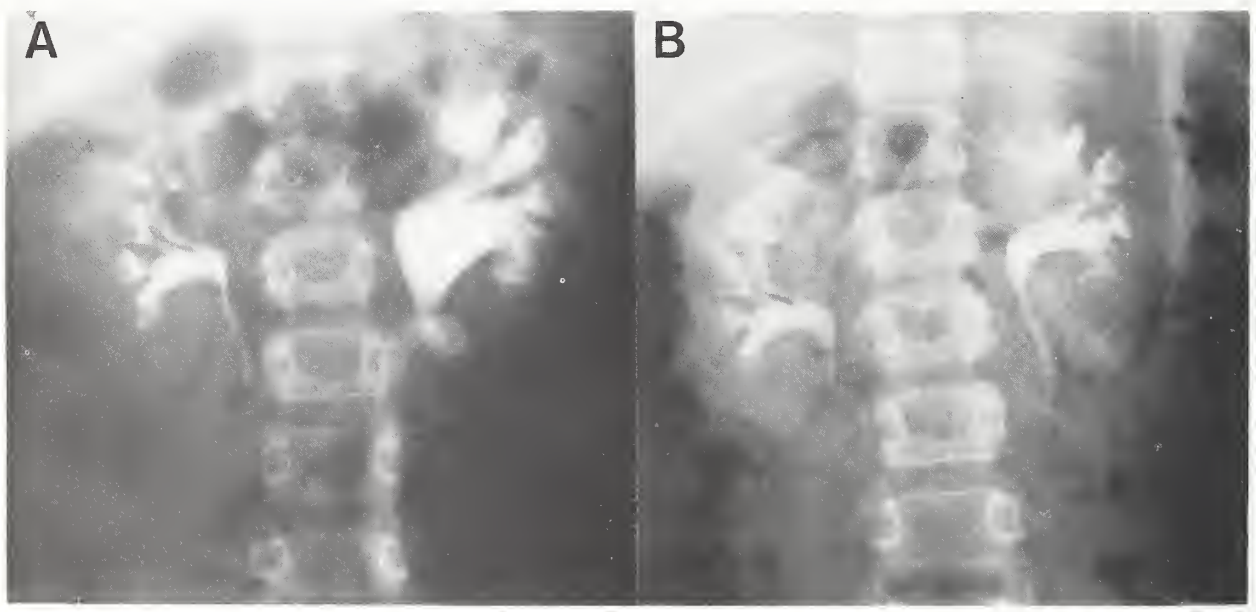
Discussion

Clean intermittent catheterization is a safe and effective means of managing the child with neurogenic bladder dysfunction. The use of a well-lubricated infant feeding tube (usually 5 French) allows easy catheterizations even in the neonate. After spinal closure, newborns with myelomeningocele often will develop urinary retention which may be temporary or permanent. Beginning CIC immediately, however, eliminates the need for a temporary suprapubic catheter or cutaneous vesicostomy. If urinary retention subsequently resolves, catheterization gradually is discontinued.

Most children with myelomeningocele have normal upper urinary tracts at birth.[6] Frequently, however, a slow progressive loss of renal function occurs. In some of these children, the intravenous pyelogram will appear stable or satisfactory from one year to the next. Consequently, it is important to compare all previous roentgenograms with the current study. This may reveal a trend of progressive renal scarring, atrophy or hydronephrosis. This process, no matter how slow its evolution, eventually can lead to chronic renal insufficiency unless early attempts are made to halt its progression.

We have seen a similar trend of slowly progressive hydronephrosis in 65 children with myelodysplasia managed in the past by ileal conduit diversion. Eighty percent of these patients have deteriorating renal units. Eight recently have been converted to antirefluxing colon conduits as an attempt in preventing further renal damage.

Although our follow-up is still relatively short, the results suggest that CIC is a better choice than the ileal conduit in protecting the kidneys of select children with neurogenic bladders. In this series, renal deterioration has occurred in only six patients (16%). Similar results have been reported by others,[7]



further narrowing the indications for urinary diversion in myelomeningocele.

The patients with stable but persistent ureteral dilation obviously require close observation. Seven of these patients have vesicoureteral reflux and in 11 there is a low-grade obstruction at the ureterovesical junction secondary to the bladder trabeculation. Although the ureteral dilatation has stabilized, it still is present. The long-term effects of catheterization in this group of patients remains unclear.

Summary

Thirty-nine children with neurogenic bladders secondary to myelomeningocele and abnormal upper urinary tracts have been managed by CIC for 6 to 48 months. In 15 patients the ureteral dilation and/or hydronephrosis improved. Eighteen children remained stable and in six cases renal deterioration occurred necessitating further surgical intervention. CIC is a safe and effective means of managing the neurogenic bladder in select children. Renal protection appears to be a major benefit of its use in patients who fail to empty their bladders completely.

References

1. Lapides J, Diokno AC, Silber SJ, et al: Clean intermittent self-catheterization in the treatment of urinary tract disease. *J Urol* **107**:458-461, 1972.
2. Hardy DA, Melick WF, Gregory JG, et al: Intermittent catheterization in children. *Urology* **5(2)**:206-208, 1975.
3. Lapides J, Diokno AC, Gould FR, et al: Further observations on self-catheterization. *J Urol* **116(2)**:169-171, 1976.
4. Drago JR, Wellner L, Sanford EJ, et al: The role of intermittent catheterization in the management of children with myelomeningocele. *J Urol* **118(1 Pt 1)**:92-94, 1977.
5. Enrile BG, Crooks KK: Clean intermittent catheterization for home management of children with myelomeningocele. *Clin Pediatr* **19(11)**:743-745, 1980.
6. Smith ED: Urinary prognosis in spina bifida. *J Urol* **108**:815-817, 1972.
7. Lyon RP, Scott MP, Marshall S: Intermittent catheterization rather than urinary diversion in children with meningomyelocele. *J Urol* **113(3)**:409-417, 1975.

MAY JOURNAL COVER

Last month, the *Journal* mistakenly omitted a credit line for its cover. The photograph on the issue entitled "DRUGS and THE HUMAN FACTOR" was taken by free-lance photographer, Larry Hamill. The *Journal* regrets the omission.

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal.* Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

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(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

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6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

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(b). References should be listed in the *order of their appearance in the text.*

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"2. Doe J, Roe RX: How to go about it. Ohio State M J 13:24-30, 1920"

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8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

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PICO (continued)

reserves must be added. Periodic adjustments in these reserves are accomplished as long-term experience is recorded. Those adjustments, if of a positive nature, should be returned to policyholders in the form of rate reductions or policyholder dividends. Of course, if the reserves are inadequate and the insurer records a loss, that loss must be passed on to the policyholders in the form of surcharges or rate increases.

Gilmore states that PICO's claims reserves, which totaled $48 million at the close of 1980, are sufficient for the company's past exposures. He also notes that the June 1 rate adjustment will help ensure that future reserves also will be adequate.

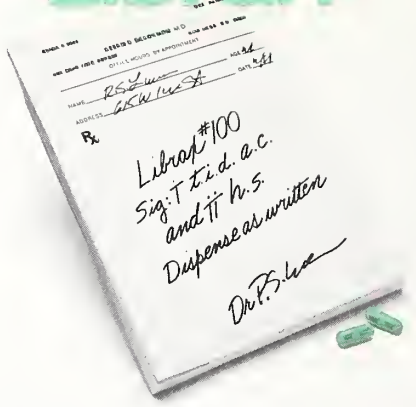
Summarizing the situation, Gilmore states that PICO's founding and continuing objective is to provide OSMA members with realistically and reasonably priced coverage throughout their medical careers.

"To do this, we have to avoid the extremes that have plagued the market in previous years, in terms of low rates which prove to be inadequate followed by heavy surcharges or lack of availability. The 'get it cheaper now and worry about the future later' philosophy simply does not work well for the doctor in professional liability insurance. By being realistic about rates and reserves on a continuing basis, we'll be able to provide the best possible service to physicians on a continuing basis."

On Wednesday, May 20, during the OSMA annual meeting in Cleveland, PICO presented a program on loss awareness that included results of the company's first claims study. This is the first of a series of ongoing programs the company plans to present to OSMA members.

While the claims study is not yet definitive, since it covers only the company's initial four years of operations, it provides insight into the medical professional liability situation in Ohio not previously available to Ohio physicians. PICO believes that by increasing physician awareness and knowledge of this situation, progress may be achieved toward the ultimate goal: a continuing decline in claims frequency and severity and a corresponding reduction in professional liability insurance premiums. OSMA

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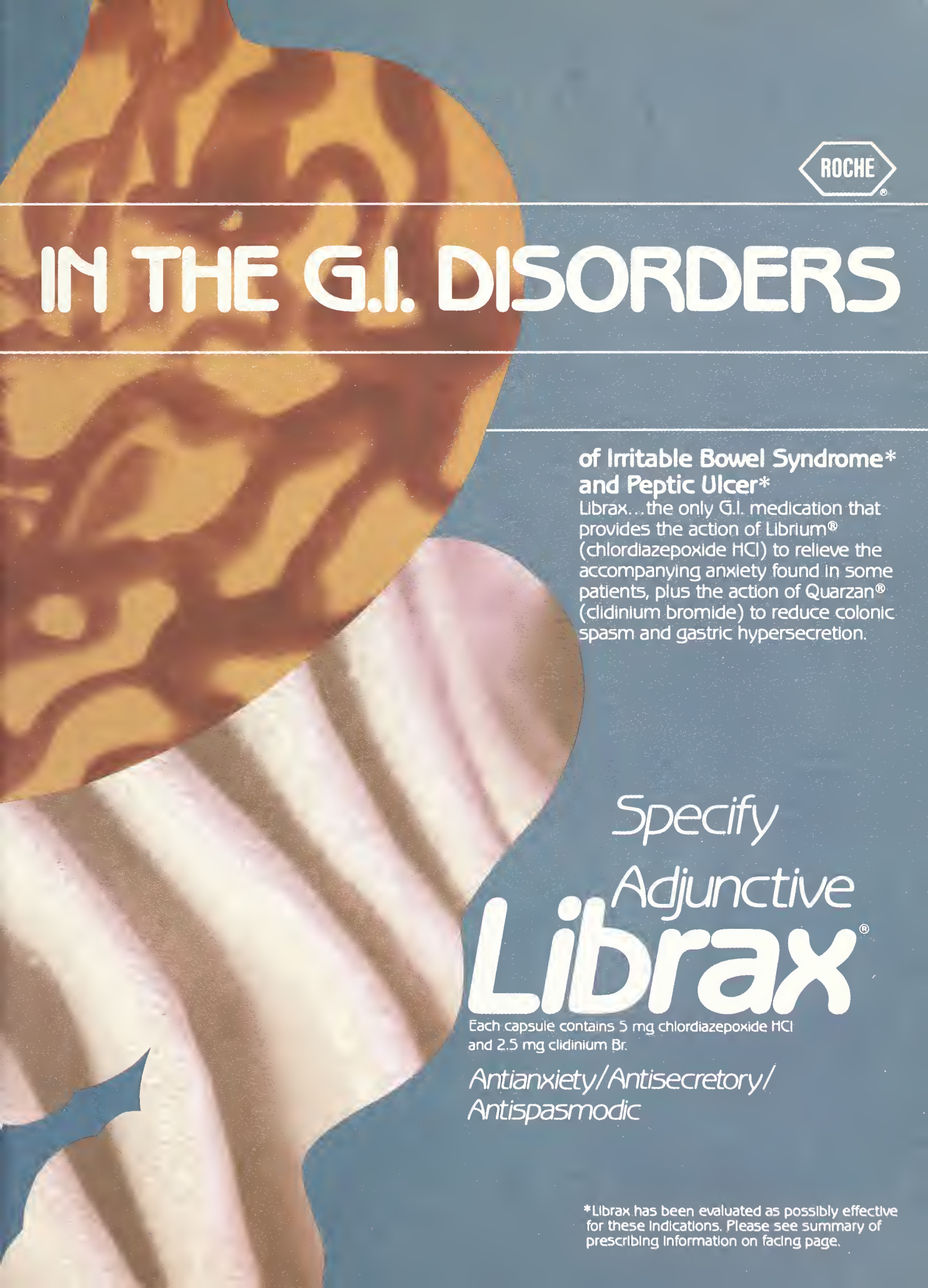
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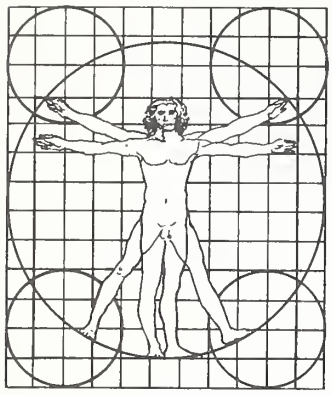
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CLINICAL & SCIENTIFIC

PROTEIN AND ENERGY REQUIREMENTS OF THE HOSPITALIZED PATIENT

Robert L. Ruberg, M.D.

Recent advances in parenteral and enteral nutrition technics have brought widespread interest in the nutritional care of hospitalized patients. Protein and energy requirements are significantly altered by malnutrition, sepsis, and trauma. This article sets forth simple guidelines for fulfilling these requirements within a variety of clinical settings.

THE FULFILLMENT OF ENERGY and protein requirements is perhaps the most critical aspect of the nutritional care of hospitalized patients. If these important demands are not met, the satisfactory provision of all other nutrient needs (vitamins, minerals, etc.) is of considerably less benefit to the sick individual.

In the following discussion we will review normal requirements for energy and protein, indicate how these are altered by disease states, describe methods for determination of energy and protein levels for hospitalized patients, and examine methods for monitoring the adequacy of a nutritional program.

Normal Requirements

Adequate amounts of energy (calories) and protein sources are necessary for maintenance of the body's equilibrium in health. This equilibrium is a *dynamic,* not a static state. The body is constantly losing protein; therefore, it must receive an amount of protein equal to its obligate losses in order to maintain a steady state. Similarly, the body is constantly burning energy sources; therefore, it must receive an amount of calories equal to the daily energy expenditure to maintain equilibrium.

The maintenance of protein equilibrium is guided by the amount of obligate nitrogen loss from the body. This loss occurs through excretion of nitrogen-containing wastes in the urine and stool plus minor contributions from the sloughing of hair, skin cells, etc. In the majority of normal individuals this loss does not exceed 0.12 to 0.13 gm of nitrogen per kg body weight per day.

As a result, a daily intake of a comparable amount of nitrogen maintains nitrogen balance. Converted to the amount of *protein* to be ingested (multiply gm N X 6.25), this calculation results in a recommended dietary allowance (RDA) for protein of 0.8 gm/kg/day.

Another important aspect of protein requirements is the provision of the proper kinds of amino acids, not just the overall amount of protein. Certain protein constituents, the essential amino acids, either cannot be synthesized at all by the body, or are synthesized in insufficient amounts. The daily diet must contain these essential amino acids in addition to those which are nonessential. The essential amino acids are illustrated in Table 1. The mnemonic PVT TIM HALL is a convenient way to remember the essential amino acids. It is important to note that histidine and arginine are *not* essential for adults, but are required in some pediatric age groups.

Certain of our usual protein sources have all the essential amino acids and are considered "complete" proteins; others

Table 1
Essential Amino Acids

P V T	T I M	H A L L
hreonine	ethionine	ysine
aline	soleucine	eucine
henylalanine	ryptophan	rginine
		istidine

Dr. Ruberg, Columbus, Assistant Professor of Surgery, Clinical Assistant Professor of Medical Dietetics, The Ohio State University.
Submitted October 27, 1980.

(for example, corn and beans) are considered "incomplete" because of one or more essential amino acid deficiencies. Since most of us eat a diet which consists of both complete and incomplete proteins, a convenient figure to remember as a satisfactory protein intake for the healthy individual, is 1.0 gm protein/kg body weight/day (instead of the RDA of 0.8).

Energy requirements for the healthy individual are dependent upon the degree of his or her physical activity. For most people with "normal" amounts of physical activity, an energy intake of 30 to 35 Kcal per kg body weight per day will maintain energy equilibrium and a relatively constant weight.

Metabolic Alterations in Disease States

In the hospital we can group patients into three categories with regard to nutritional requirements: (1) normal; (2) malnourished; and (3) stressed patients. Examples of the "normal" patients may include those being readied for elective surgery, or undergoing "routine" diagnostic evaluation. These patients, according to various authors, may constitute only a minority of hospitalized patients,[1,2] since malnutrition has been shown to be much more prevalent than previously suspected. For these patients, standard requirements should be satisfactory.

The malnourished patients can include those with malignant diseases, renal disorders, gastrointestinal malfunctions, etc. The metabolic demands in these patients for the most part can be met by increasing somewhat the levels of all nutrients to restore the deficits which exist.

In the stressed patients, we find the most significant alterations in metabolic processes and the highest demand for energy and protein substrates. Under the influence of various hormonal alterations,[3] an elevation of metabolic rate occurs as a consequence of stress, irrespective of whether the stress is produced by accidental trauma, a surgical procedure, or sepsis. The magnitude of this response is proportional to the degree of stress, and can be measured as percent increase in energy expenditure over levels seen in a "resting" state (sometimes called the resting metabolic expenditure, or RME). Data collected by Long, et al[4] (Table 2) show the percent increase in energy expenditure above RME in various stressed states. These values range from a mild increase (24%) in elective surgery patients to a massive increase (131%) after major thermal burn.

An additional energy demand occurs with sepsis. Each 1°C rise in temperature increases the energy expenditure by 10%. Thus a patient will require about 30% more calories when his temperature is 104°F compared to when it is normal.

To maintain energy equilibrium, we must supply extra calorie sources in amounts proportional to the degree of stress in these patients. The changes in protein balance produced by stress parallel the alterations seen in energy balance. With increasing levels of stress, there is a comparable elevation in the level of nitrogen excreted. Long's data[4] (Table 3) show a range of urinary nitrogen excretion from 0.21 gm/kg body weight/day for mild stress (elective surgery) to 0.37 gm/kg/day for severe stress (major burn). When insufficient exogenous nitrogen (as protein) is fed to the patient, these urinary nitrogen losses represent breakdown of a significant proportion of the skeletal muscle mass.

To maintain nitrogen equilibrium, extra amounts of protein, in proportion to the degree of stress, must be supplied.

The hormonal changes which direct the events described above probably stem from an alteration in the insulin-glucagon ratio, as Wilmore[3] and others have shown in burn patients. Under the influence of relative glucagon excess, the body breaks down protein to supply the raw materials for gluconeogenesis. Glucose stores in the body (glycogen) are inadequate to supply energy needs for even 24 hours; the continuing demand for glucose in the stressed state therefore is met by destruction of a critical component of body structure, muscle protein.

Table 2
Increase in Energy Expenditures Following Injury and Illness

Elective surgery	24%
Skeletal trauma	32%
Blunt trauma	37%
Trauma with steroids	61%
Sepsis	79%
Burns	131%

adapted from Long, et al, JPEN 3(6):452-456, 1979.

We strive to maintain a relatively steady state by supplying calories and protein in sufficient amounts to the stressed patient, helping him or her to survive this often life-threatening disease state.

Determination of Caloric and Protein Requirements

Several different methods for determining energy and protein requirements for hospitalized patients have been described. Blackburn, et al[5] suggest first calculating the basal energy expenditure (BEE) according to the formula of Harris and Benedict. Based on height (H), weight (W), and age (A):

For men: BEE = 66 + (13.7 X W) + (5 X H) − (6.8 X A)

For women: BEE = 655 + (9.6 X W) + (1.7 X H) − (4.7 X A)

(This basal expenditure represents energy needs in a condition of *no* physical activity.)

Then Blackburn advises giving 1.5 X BEE for enteral feeding and 1.75 X BEE for parenteral feeding, in order to achieve protein anabolism and adequate energy balance. Although useful as a rough guideline, this formula does not take into account different levels of stress.

Long[4] has proposed a more sophisticated way to estimate energy requirements, according to the formula:

BEE X (activity factor) X (injury factor)

The Harris Benedict standard is multiplied by an activity factor (1.2 for patients confined to bed, 1.3 for those out of bed), then multiplied by an injury factor (1.20 for minor surgery, 1.35 for skeletal trauma, 1.60 for major sepsis, 2.10 for severe thermal burn). Although this method is more exacting, it still does not provide for real accuracy because of the great variability between patients. Nevertheless it should provide a useful point for initiating nutritional therapy.

After thermal injury the energy requirements may be estimated by using the formula proposed by Curreri, et al,[6] for the "Ideal Caloric Intake" in burn patients:

25 X (Weight in kg) + 40 X (percent burn)

This formula takes into account differences in body size and alterations in degree of stress as measured by amount of surface area burned.

Protein requirements may be determined by first estimating total energy requirements, then aiming for a calorie-to-nitrogen ratio of 150:1.[7] This calculation yields a value for daily protein intake by multiplying by 6.25 (6.25 gm protein contain about 1 gm nitrogen).

For burn patients, one might wish to use the protein guidelines of Larkin and Moylan:[8] 1.5 to 2.0 gm protein/kg body weight/day for young adult males, and 1.0 to 1.5 gm/kg/day for all others.

Table 3
Urinary Nitrogen Losses Following Injury and Illness

Elective surgery	0.21 gm/kg/day
Skeletal trauma	0.32 gm/kg/day
Blunt trauma	0.32 gm/kg/day
Trauma with steroids	0.34 gm/kg/day
Sepsis	0.37 gm/kg/day
Burns	0.37 gm/kg/day

adapted from Long, et al, JPEN 3(6):452-456, 1979.

Evaluation of Adequacy of Nutritional Therapy

Once a dietary regimen has been established, it becomes necessary to ascertain the adequacy of this program. Providing nutrients according to a formula may not be adequate — if demands prove to be higher than original estimates, then the nutritional program must be revised accordingly.

The simplest ways to determine dietary adequacy are routine clinical observations: weight gain, wound healing, fistula closure, etc. A more sophisticated method of measuring dietary adequacy is through the determination of nitrogen balance. An exact nitrogen balance requires accurate knowledge of protein intake plus collection and measurement of all urine and stool nitrogen.

In most clinical settings this detailed technic is not practical; however, a simplified method for estimating nitrogen balance exists: measurement of 24-hour urine urea nitrogen (UUN) levels can be easily done (collect all urine for 24 hours, obtain a UUN value on a sample, then convert this value for the total specimen).

As a general rule, the UUN level is about 4 gm less than the total 24-hour nitrogen excretion, irrespective of the magnitude of stress. With this approximation, plus a knowledge of the nitrogen intake, one can roughly determine whether a patient is in positive or negative nitrogen balance. If the patient is in negative balance, then clearly the initial estimates of caloric and protein needs were inadequate, and a revision of the nutritional program is in order.

Additional laboratory measurements may be used to assess the adequacy of any nutritional program. Serum albumin levels are important determinants of nutritional state at the start of therapy, but unfortunately are not useful as a serial measure of the progress of therapy. On the other hand, total iron binding capacity and/or transferrin levels[9] are quite sensitive to changes in nutritional state, and probably are the most useful serial measure of the adequacy of a nutritional program.

Conclusions

Energy and protein supplies are the keys to adequate nutritional therapy in hospitalized patients. We know that malnutrition and especially stress increase our protein and energy demands. Fortunately, we now have some fairly simple ways to estimate these extra demands. With a rational approach to nutritional therapy, we should be able to meet or exceed the energy and protein requirements of virtually all hospitalized patients.

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Worth Quoting

"There has been a lot of jubilation in business circles in recent weeks. People have been talking as though industry's problems are as good as solved. That with friends in high places, we need only make known our wishes and watch the fetters fall away. This sort of talk is naive; it reflects scant understanding of the way Washington works.

One factor which always acts as a sea anchor to change is the bureaucracy. Most of the operational rules and restraints that circumscribe business activity are not set out in the laws Congress passes. They are contained in the implementing regulations written by dozens of federal agencies.

These agencies are entrenched interests in their own right. Many of them have strong ideas about how the world ought to work. Some of them are quite unresponsive to the dictates of their nominal masters. All of them are complicated and difficult to get a handle on for an incoming administration.

For a new president, dealing with a recalcitrant agency can be like fighting an unfamiliar prehistoric monster. He can stab it high and stab it low, but if he doesn't know where its vital organs are, he is likely to wear himself out before he even gets its attention."

Lewis A. Engman
Pharmaceutical Manufacturers Assn.

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Features

Industrial accidents: Finding the cause may help find the cure 402
William W. Johnston
Statistics on industrial accidents — where they happened, how they happened, why they happened — are presented here by the Industrial Commission in hopes that the information they contain will prove useful in preventing future accidents from occurring.

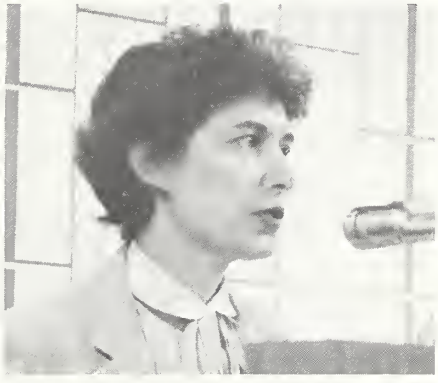
The Auxilians' "Day at the Legislature" 404
Jennifer O'Brien
The Auxilians' annual trip to Columbus to "meet their legislators" is covered here in pictures.

A Management Seminar for Senior Residents 407
J.D. McCue, M.D.; D.M. Waggoner, M.D.; and P.M. Holdorf, Ph.D.
The authors discuss a special seminar, set up to help Senior Residents assume the organizational and management responsibilities they need in their new, authoritative roles.

1981 OSMA Annual Meeting Section 411
House of Delegates reports, actions on resolutions and pictorial highlights of OSMA's week in Cleveland are all included in this special section.



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Our Cover

Mrs. Vera Kalnins captured her second award in this year's photographic exhibit contest with this picture entitled "Moss Rose."

Clinical and Scientific

Sudden Hearing Loss 457
Alan J. Sogg, M.D.

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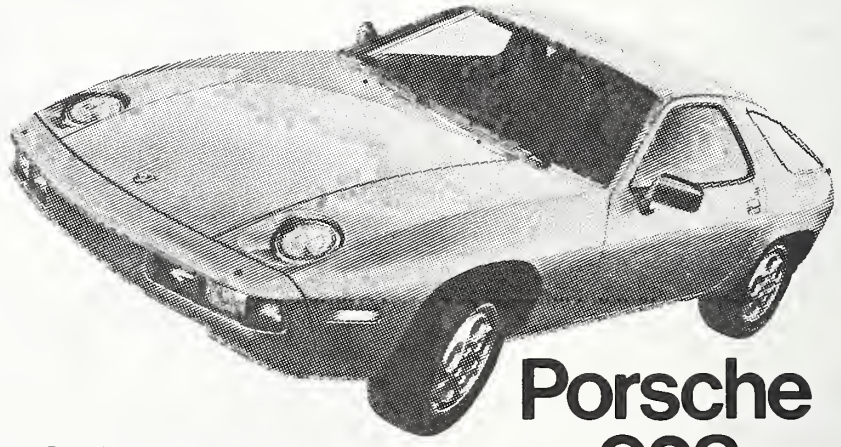
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Letters ...to the editor

Clearing confusion

To the Editor:

If you propose to add a word to your readers' vocabulary, please spell it correctly:

rapel(*sic*): Descent from a height by means of a rope passed under one thigh, across the body, and over the opposite shoulder.

Webster's New Collegiate Dictionary, Merriam-Webster Publishing Co., Springfield, Mass., 1974.

Good medical writing demands exquisite accuracy in details.

(unsigned)

Editor's Note:

While this wasn't the first note the Journal received on this subject, it was the first one to offer this particular spelling of the word.

According to Webster's New Collegiate Dictionary, Merriam-Webster Publishing Co., Springfield, Mass., 1980, the word is spelled **rappel.** *We hope this clears any lingering confusion that may remain on the matter.*

Drug issue bouquets

To the Editor:

Just a line or two to congratulate you on a very fine issue of the *Ohio State Medical Journal* appearing in May, 1981.

The subject of drug abuse formed a wonderful nucleus for the rest of the material in the issue, and from Perry Ayres' excellent contributions through the State Medical Board to the Pharmacy Board, all of the items were factual and beautifully presented.

On behalf of the State Medical Board, we appreciate your dexterous presentation concerning our efforts and our accomplishments.

Many thanks and with kindest personal regards.

Sincerely yours,
/s/**Anthony Ruppersberg, Jr., M.D.**
Secretary

To the Editor:

The article on "Patient Package Inserts" which you helped me develop was super. The emphasis you placed and the title you gave to the article was most appropriate.

I really appreciate being given the opportunity to express myself in the *Journal* on a subject that I felt very deeply about.

Sincerely,
/s/Robert S. Young, M.D.

To the Editor:

Congratulations on your issue, Vol. 77, No. 5 for May 1981. The Issue is taken up with so many good things, in an intelligent manner, that it should be required reading for all practitioners. The 'Drug Scene' and its environs are of tremendous importance to all of us. We do not know enough about the various chemical reactions that take place in the body when the various medications are put into it. Also, concisely are found the limitations and guides for the prescribing and use of "Controlled Drugs." All of that in one issue is of tremendous importance.

I, for one, have been inclined to prescribe for every little symptom that arises and I find, through experience gained in the nursing homes, that it is not necessary nor good to continue the use of these drugs for long periods of time. The interdiction through the judicious use of "Drug Holidays" is of tremendous importance. Drug 'Stop Orders' for all drugs and the periodic review of the drug usage would be of great importance. Also, the use of 'new drugs' just because they are new is not always good. Some of the older drugs that are good in their effects and produce less in the way of side effects would be good.

The references to the other agencies, that have the responsibility and functions for seeing about the usage of drugs, are also good. I should also like to see the impressions in this regard of the hospital nurses and the druggists, who put their time in in the hospital pharmacies. Medicine is not, any more, wholly a single concern but rather it is the concern of all of us in the drug and medical fields. The doctor should be in control of the case, but he should seek the assistance of others who know more about the drugs and their effects. Also, the practicing physician, who knows his patient, will also know the differing reactions of his patient to the different drugs and how to manage these in the best interests of the patient more so than would the emergency room physician.

Again, congratulations on a concise issue and keep up the good work.

Yours truly,
/s/**Chester H. Allen, M.D.**
Portsmouth, Ohio

COLLEAGUES IN THE NEWS

B. B. CAPLAN, M.D., Columbus, is one of the recipients of the 1981 Jefferson Awards. Dr. Caplan is being honored for his continued involvement and service to the elderly and youth. Dr. Caplan has been awarded the Ohio Physician of the Year Award by the Ohio Nursing Home Association, the Ohio State Governor's Award for Humanitarianism, Man of the Year Award from the Organization for Rehabilitation Through Training, the American Medical Association Service Award, and has been selected to Who's Who in America.

The following were elected officers of the Ohio Chapter of the American College of Radiology: **D. KIEFER CAMPBELL, M.D.**, Dayton, president; **CHARLES M. KLEIN, M.D.**, Toledo, president-elect; **LAWRENCE G. THORLEY, M.D.**, Amherst, secretary; and **KONRAD KIRCHER, M.D.**, Dayton, treasurer.

JAMES J. ENYEART, M.D., Girard, was named program director of the Family Medicine Center of St. Elizabeth Hospital Medical Center. Dr. Enyeart is an assistant professor in family medicine at the Northeastern Ohio Universities College of Medicine and has directed St. Elizabeth's four-year clinical experience program for students of the medical school.

JAMES M. GARVEY, M.D., Weirton, was named liaison fellow at Weirton Medical Center for the Commission on Cancer program of the American College of Surgeons. Dr. Garvey is a surgeon and has been a member of the Weirton Medical Center medical-dental staff since 1968.

HELEN I. GLUECK, M.D., Cincinnati, was one of the winners of the 1981 Career Women of Achievement Awards, sponsored by the Cincinnati YWCA. Dr. Glueck is professor emeritus, department of medicine; director, coagulation laboratory, department of pathology, University of Cincinnati College of Medicine.



Sidney A. Peerless, M.D.



Roslyn Seligman, M.D.

JOHN W. VESTER, M.D., Cincinnati, has joined the WKRC-TV evening news team as one of the *The Experts*, four panelists who comment on medicine, law, economics, and theater. Dr. Vester's segment will appear on alternate Thursdays on Channel 12's 5:30 pm newscast.

CHRISTOPHER KIRCHER, M.D., continues as the host of *To Your Health* on WCPO-TV's *7 O'clock Report*.

GEORGE HAMILTON, M.D., Euclid, was elected chief of staff of Euclid General Hospital. Dr. Hamilton is an anesthesiologist.

HENRY J. HEIMLICH, M.D., Cincinnati, was awarded the 1981 distinguished service award by the American Society of Abdominal Surgeons for his medical achievements, especially his development of the Heimlich maneuver. Dr. Heimlich is professor of advanced clinical sciences at Xavier University.

JOHN HUDEC, M.D., Cleveland, was elected chief of staff at Deaconess Hospital. **ISIDRO AMIGO, M.D.**, was elected vice chief of staff, and **GENE BOYCHUK, M.D.**, was elected secretary-treasurer.

ALLEN G. JACKSON, M.D., Bryan, has accepted the position of program coordinator of the newly formed Bryan Area Health Education Council (BAHEC). Dr. Jackson is a pediatrician at the Bryan Medical Group, Inc.

ROBERT L. KUNKEL, M.D. and **HORATIO C. WOOD, M.D.**, Cincinnati, were appointed co-medical directors at Emerson A. North Hospital. Drs. Kunkel and Wood are psychiatrists and hold faculty positions at the University of Cincinnati. Dr. Kunkel is president of the Cincinnati Psychiatric Society and Dr. Wood is the Society's representative to CORVA.

J. J. McLAUGHLIN, M.D., Cleveland, was elected president of St. John Hospital medical staff. **E. G. KILROY, M.D.,** was elected vice president and **J. J. GAUGHAN, M.D.,** secretary-treasurer.

SAMUEL MEITES, M.D., Columbus, will receive the "Award for Outstanding Contributions Through Service to Clinical Chemistry as a Profession" from the American Association for Clinical Chemistry. Dr. Meites is the director of the clinical chemistry laboratory at Children's Hospital.

ROBERT J. PRICE, M.D., Troy, was appointed to serve a four-year term on the Tri-County Board of Mental Health. Dr. Price has been in private practice in Tipp City since 1961.

The 1981 Guardian of the Menorah Award was presented to **SIDNEY A. PEERLESS, M.D.,** Cincinnati. Dr. Peerless is director of otolaryngology at Jewish and Providence Hospitals and assistant clinical professor in the department of otolaryngology and maxillofacial surgery at the University of Cincinnati College of Medicine.

WILLIAM SCHULTZ, M.D., Wooster, recently received an award from the Ohio Hospital Association for seven years of exceptional service as "member-at-large" on the OHA's board of trustees. Schultz has practiced medicine in Wooster since 1946. He has been a member of the Ohio State Medical Association since 1942 and served as its president in 1972 and 1973. He was an alternate member to the American Medical Association House of Delegates from 1974 to 1976.

ROSLYN SELIGMAN, M.D., Cincinnati, was installed last month as president of the Ohio Psychiatric Association. Dr. Seligman is an associate professor of psychiatry (child and adolescent) at the University of Cincinnati College of Medicine and psychiatric consultant to adolescent clinic of Children's Hospital Medical Center.

HECTOR SIAT, M.D., Carlisle Township, was appointed to the Elyria Health Board. Dr. Siat has practiced in Elyria since 1963 and is currently treasurer for the Elyria Memorial Hospital's medical staff.

HOWARD H. SOKOLOV, M.D., Cincinnati, was appointed commissioner of the Division of Mental Health and Forensic Psychiatry of the Ohio Department of Mental Health. Dr. Sokolov is assistant professor in the department of psychiatry at the University of Cincinnati and adjunct assistant professor of medical jurisprudence at the University's College of Law.

The following were elected officers of the Ohio State Coroners Association: **JOSEPH SUDIMACK, JR., M.D.,** Trumbull County, president; **ROGER PEATEE, M.D.,** Wood County, vice president; and **S. R. GERBER, M.D.,** Cuyahoga County, secretary-treasurer.

JOHN W. VESTER, M.D., Milford, was commissioned as a colonel in the U.S. Army Medical Reserves in ceremonies held at the Pentagon in Washington, D.C. Dr. Vester served in a MASH unit during the Korean War. He is director of clinical laboratories and chairman of the section of endocrinology at Cincinnati's Good Samaritan Hospital, and associate professor of medicine and biochemistry at University of Cincinnati's College of Medicine.

ROBERT M. ZOLLINGER, M.D., Chagrin Falls, was named president and chairman of the board of the Cleveland Academy of Medicine. Dr. Zollinger is an associate professor of surgery at Case Western Reserve University and associate surgeon at University Hospitals and Metropolitan General Hospital.

Also elected were: **RAY W. GIFFORD, JR., M.D.,** president-elect; **RICHARD B. FRATIANNE, M.D.,** vice president; and **HENRY GEORGE KRUEGER, M.D.,** secretary-treasurer.

OSMA's Distinguished Alumnus



Albert Sabin, M.D., accepted OSMA's Distinguished Service Award last year

Albert Sabin, M.D., who was presented with the Ohio State Medical Association's "Distinguished Service" award last year, has recently completed the testing of his new measles vaccination mist for infants, and is currently enjoying his retirement in Charleston, South Carolina at the age of 75.

The vaccine mist which Dr. Sabin has developed, is a fine mist — finer than the spray from an atomizer — which is directed into a baby's open mouth, while the nostrils are held closed so the child will inhale. It was tested this past May in Mexico City on 320 infants, through a cooperative venture involving Dr. Sabin, Dr. Manoel Ramos-Alvarez of the Mexican Health Ministry, and the National Institutes of Health.

The success of the new mist could mean that mass inoculations will be possible in underdeveloped countries, where measles is still a deadly disease, because persons with no medical training will be able to administer it.

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STATE

The AMA in conjunction with the American Bar Association, American Academy of Neurology, American Electroencephlographic Society, the National Conference of Commissioners on Uniform State Laws, and the President's Commission for the study of Ethical Problems in Medicine and Biomedical and Behavioral Research drafted a model bill to provide for the legal determination of death and submitted it to the states for adoption. The bill states "an individual is dead if he has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards."

The Ohio State Medical Association's House of Delegates at its 1980 Annual Meeting adopted a resolution directing the OSMA to actively support legislation based on this model. At the request of the OSMA Department of State and Federal Legislation, Senator Paul Matia (R-Westlake) introduced this legislation as Senate Bill 98. In late April, SB 98 passed the Ohio Senate. The bill is currently before the House Judiciary Committee.

In the not-too-distant past, the diagnosis of death was a simple matter. Death was medically and legally recognized as the state of "irreversible cessation of circulatory and respiratory function" — a straightforward reflection of society's understanding of death. Somewhat ironically, however, recent advances in medical science (ie, resuscitative and supportive technology) have made the traditional criteria obsolete in some cases.

The medical profession has recognized, and is employing, an alternative means of determining death based upon neurological criteria. To date, twenty-nine states have legislatively, or judicially, recognized death of the brain as an acceptable means for determining death. Ohio is not one of those states, but with SB 98 the Ohio General Assembly is currently debating the issue.

As a matter of public policy, a point must be established at which an individual is no longer treated as living. The social, legal, ethical, and economical consequences of failing to establish such a point are immense. If, because of the intervention of artificial life support systems, a physician is precluded from making a determination of death based on cessation of heart and lung function, then an alternative means of determining death must be utilized. That alternative is the "irreversible cessation of all functions of the brain, including the brain stem."

It is the brain which controls the integration of internal bodily functions (ie, respiration, circulation, motor control) as well as the capacity for integrating with the external environment (ie, reasoning, rationality, consciousness, etc.). The death of the brain is an accurate indicator of the death of the being.

Any law dealing with the determination of death must be based upon a socially acceptable concept of death. Society has generally agreed that death occurs at the point when man irreversibly loses that which is considered essentially significant to man. What has been considered "essentially significant" is the individual's capacity for integrating internal bodily functions in conjunction with the capacity for integrating oneself with the social or external environment.

The irreversible loss of heart and lung function is a definitive diagnosis of death. In the overwhelming majority of cases it is still used. However, in those cases in which a physician is precluded from making a diagnosis of irreversible loss of heart and lung function due to the intervention of supportive technology, the logical point to look for detection of the loss of the essential characteristics is the brain. Circulatory, respiratory and neurological activity are closely interrelated functions. The cessation of one leads to the cessation of all within a short time. The use of neurological criteria for the determination of death is a logical extension of the recent advances of medical science and is consistent with society's understanding of the nature of death. That is the substance and intent of SB 98. It does not provide for an "alternative definition of death." Indeed it does not even "define" death, but simply provides for an alternative means of determining when death has occurred.

Currently, Ohio statutes do not address the determination of death. Ohio case law recognizes only the traditional circulatory and respiratory criteria. Therefore, it is conceivable that Ohio physicians might technically be held liable for the cessation of treatment of an individual diagnosed as dead upon the basis of neurological criteria.

The enormous financial and emotional costs, the adverse effects on morale of health-care personnel, and the restriction of the physician's access to viable organs for potentially life-saving transplants is too high a price for society to pay. The dichotomy existing between the legal and medical communities on this issue should be put to rest. For these reasons, SB 98 should be enacted into law and the physicians of Ohio allowed to concentrate on their role of treating the living. OSMA members are urged to discuss this legislation with the members of the Ohio House of Representatives to explain the significance of SB 98.

MEDICAL LICENSURE BILL REINTRODUCED

Representative Dean Conley (D-Columbus) has reintroduced a measure to revise Ohio's medical licensure laws. House Bill 565 is essentially a redraft of HB 1047, the bill Representative Conley introduced last session. Like HB 1047, HB 565 recognizes Canadian medical school accreditation as the equivalent of U.S. medical school accreditation. The bill also requires foreign-born graduates of foreign medical schools to show evidence of graduation from a school approved by the State Medical Board, hold certification from the Education Commission for Foreign Medical Graduates, and complete twenty-four months of post-doc-

toral training. For U.S. citizens studying medicine abroad, HB 565 establishes board approval of the school as a condition for licensure in Ohio. Currently, a graduate of a medical school listed by the World Health Organization listing may sit for licensure in this state.

HB 565 has been referred to the House Education Committee.

LEGISLATION PROPOSED TO EXTEND MANDATORY MENTAL HEALTH AND ALCOHOLISM COVERAGE

Senate Bill 336 (Cox, D-Barberton) and Senate Bill 365 (Van Meter, R-Ashland) have been introduced to extend mandatory insurance coverage for mental health and alcoholism treatment, as enacted by SB 90 of the 112th General Assembly. Because SB 90 contained a sunset clause, mandatory insurance coverage for mental health and alcoholism treatment would automatically be repealed unless continuing legislation is enacted this session.

SB 365 is a straight elimination of the sunset clause in SB 90. SB 336 proposes further revisions in mandatory insurance coverage for mental and emotional disorders and alcoholism. These proposed changes include (1) replacement of the $500 annual minimum coverage with a twenty-visit minimum mandate, (2) granting authority to the State Medical Board and State Board of Psychology for the establishment of "performance standards" for clinical supervision, and to the Department of Mental Health for standards of peer review and utilization review, (3) elimination of permissive deductibles and co-insurance costs, (4) insertion of new accreditation and certification agencies, (5) provision for interchangeability of days of hospitalization, and (6) provision for reimbursement on the basis of "prevailing rates for similar services" in Ohio.

Both bills have been referred to the Senate Elections, Financial Institutions and Insurance Committee.

EMERGENCY MEDICAL SERVICES AGENCY PROPOSED

Legislation has been introduced creating an Emergency Medical Services Agency within the state Adjutant General's department. Senate Bill 271 (Finan, R-Cincinnati) is the product of several years' work by the Governor's Emergency Medical Services Advisory Council. The bill requires the Adjutant General to act as the director of the agency, and to appoint a physician with emergency medical experience as the chief medical officer. The proposed agency would be responsible for establishing and maintaining "a comprehensive program for the planning, development, improvement, expansion, and upgrading of emergency medical services throughout the state." Under the bill, the agency would seek to establish state, regional, and local emergency medical services operations in areas of the state where none exist.

SB 271 has been referred to the Senate State Government and Federal Relations Committee.

ABORTION OVERVIEW

Several bills dealing with abortion have been introduced this session. House Bills 92, 93 and 94, when considered together, are a redraft of HB 879 (Rocco, D-Parma), the abortion bill from last session. The most active bill of the three has been HB 92 (Rocco, D-Parma) which expands the informed consent required for abortion. HB 92 has received extensive hearings in the House State Government Committee. By a recent subcommittee vote, HB 92 has been indefinitely postponed. A vote of indefinite postponement means it will be quite difficult for proponents of HB 92 to receive further hearings in the committee this session.

HB 93 (Suster, D-Euclid), prohibits abortion beyond the time when a fetus becomes viable, except in those cases when an abortion is necessary to preserve the life or health of the mother. The bill also requires the presence of two physicians during abortion of a viable fetus. HB 94 (Suster, D-Euclid) expands the recordkeeping required of an abortion facility, and requires all "abortion facilities," including a physician's office if abortions are performed there, to be registered and inspected by the Ohio Department of Health. HB 93 has been referred to the House Judiciary and Criminal Justice Committee and HB 94 has been referred to the House Health and Retirement Committee. Neither bill has received hearings.

Other house-sponsored legislation, HB 495 (Galbraith, R-Maumee) would require all county welfare departments to pay up to five hundred dollars for an abortion or tubal ligation at the request of a pregnant mother receiving aid to dependent children (ADC) funds. HB 495 has been referred to the House Finance and Appropriations Committee. In addition, House Joint Resolution 29 (Luebbers, D-Cincinnati) petitions Congress to call a Constitutional Convention for the purpose of guaranteeing the unborn the "right to life."

Two Senate measures introduced this session also deal with abortion. SB 315 (Kasich, R-Westerville), like HB 92, expands the informed consent required for an abortion, and has been referred to the Senate Health and Human Resource Committee. Senate Joint Resolution 20 (Finan, R-Cincinnati) like HJR 29, petitions Congress to call a constitutional convention for the purpose of amending the constitution to guarantee a "right to life" for the unborn.

FEDERAL

MINORITY OR MAJORITY?

While the Senate is controlled by the Republicans and the House is controlled by the Democrats, you could not tell from the recent actions of two panels that deal with health legislation. Neither Orrin Hatch (Chairman of the Senate Labor and Human Resources Committee) nor Henry Waxman (Chairman of the House Commerce Committee's Health Subcommittee) are now able to control an effective majority on important issues.

While holding an 11-7 Democratic majority, Congressman Waxman has two Democrats, Phil Gramm (Tex.) and Richard Shelby (Ala.), who are often more than eager to support the President and side with ranking minority member Edward Madigan (R-Ill.), thereby bringing about a tie on important votes. In the Senate Human Resources Committee, Senator Kennedy often can get a tie on votes with the vote of Lowell Weicker (R-Conn.) and can sometimes defeat the majority when he can get Robert Stafford (R-Vt.) to vote with him.

BOOK SHELF

Current Medical Information and Terminology. *Published by the American Medical Association.*

The fifth edition of what has become AMA's "official" volume for naming and describing diseases and medical conditions is now available, detailing some 6,200 diseases within its pages. All information in the book is condensed for quick reference, but because the volume is intended for diagnostic assistance only, **no** information regarding **treatment** of the described diseases is included.

The book is available from Order Dept. OP-337, American Medical Association, P.O. Box 821, Monroe, Wi. 53566. Single copies are $20.00 plus $4.00 for postage and handling.

Nutrition and Medical Practice. *Edited by Lewis A. Barness, M.D., Yank D. Coble, M.D., Donald I. MacDonald, M.D., and George Christakis, M.D., AVI Publishing Company, Inc.*

When the Florida Medical Association's *Journal* published a special issue on nutrition, response was so great that the authors became convinced of the urgent need for an authoritative treatise on nutrition for use in medical education, and in the medical community as a whole.

As a result, Nutrition and Medical Practice features discussions of more than 30 specialized areas which will aid practitioners in the prevention, recognition, and treatment of nutrition-related diseases. Important information is given on dietetic support in medical practice and how to get nutritional help at home or in the office. Pertinent references in nutrition information are included for the physician and the patient.

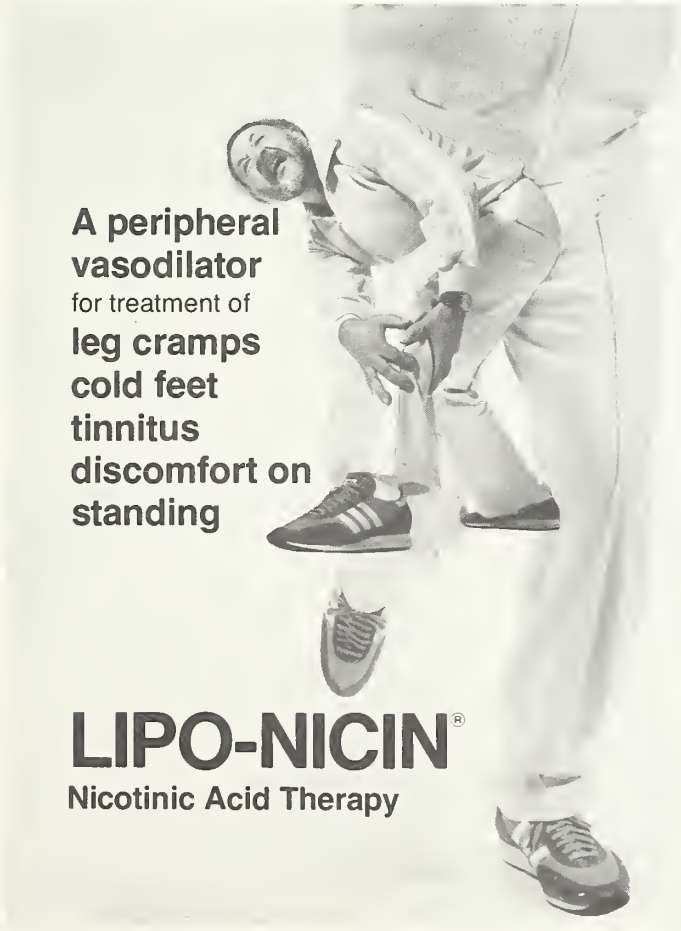
The book may be obtained for $19.50 per copy by writing the publisher: AVI Publishing Co., Inc., 250 Post Rd., E., P.O. Box 831, Westport, Connecticut 06880.

Drug Abuse: A Guide for the Primary Care Physician. *By Bonnie B. Wilford. The American Medical Association.*

This book is written specifically for the physician who is treating drug abusers among their patients. It deals with the causes, incidence, diagnosis, and treatment of drug abuse, and airs both medical and psychological implications of the problem. Pointers also are given on prescribing practices that will curb abuse of regular prescription drugs.

Also contained within the book are guides to chemical, proprietary, and popular names of commonly abused drugs; physical signs of acute drug reactions; tests to confirm suspected drug abuse; steps in treatment planning; and state and federal drug abuse agencies.

The book can be obtained by writing: Order Dept. OP-323, American Medical Association, P.O. Box 821, Monroe, Wi. 53566. Single copies are $15 plus $2 for handling.



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Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
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Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

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NEWS

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edited by Karen S. Edwards

JCAH predicting overhauls

The Joint Commission on the Accreditation of Hospitals (JCAH) has recently voted to rewrite JCAH standards to focus on elements essential to quality patient care; to simplify and remove ambiguities; and to promote flexibility in their application to different types of facilities, said John E. Affeldt, M. D., President of JCAH, recently.

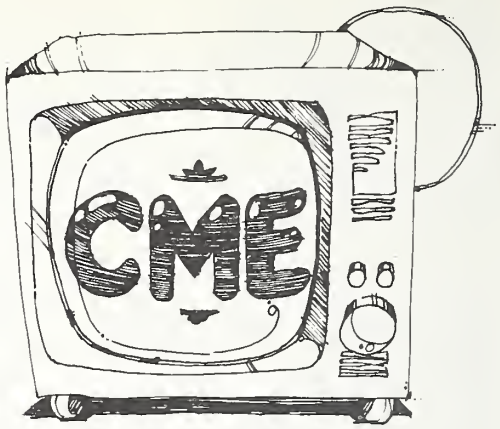
As a result, in the future, each facility will be encouraged to determine the most suitable methods of meeting the standards based on consideration of its own situation and circumstances.

The Board also voted to explore changes in the survey process. Among the changes suggested were:

- Lengthening the accreditation cycle beyond two years.
- Targeting surveys to the areas of greatest need in hospitals.
- Strengthening the "peer review" and consultative aspects of the accreditation process.

"Although many of these actions do not have immediate impact on the current accreditation process, they are important steps that will lead to major changes," Dr. Affeldt said.

Armchair credits . . . sponsored by OSMA



The Ohio State Medical Association (OSMA) has recently taken a step which may well launch the earning of mandatory continuing education requirements into the next century.

Through a cooperative venture with the Southern Medical Association, the OSMA is now offering its members access to a "Telecourse System" — a system of programmed videotapes, fully accredited and designed to help the physician earn his CME credits in the most convenient manner possible — either at home or in his office.

Described as an "electronic medical journal," Telecourse System actually takes a full spectrum of medical subjects and puts them into the easily digestible, quickly disseminated medium of television.

Currently, 500 Telecourses are available — each prepared by a leading medical school, hospital, or research center, and carefully screened by an Editorial Board. The tapes are then accredited for AMA Category I and V credit; AAFP prescribed credit; or ACOG cognates. Subjects and descriptions are categorized according to specialty. As a result, the physician can easily stay current with recent information that specifically fits the needs of his/her practice, while effectively managing his or her own time.

A subscription to the Telecourse System, with or without the latest RCA video equipment is, of course, tax deductible.

For further information, please call Roy Evans or Warner Stough at 1-800-874-9740.

The case of the disappearing allergy

Most people who think they are allergic to penicillin actually aren't, says a report in a recent issue of the **Journal of the American Medical Association.**

As many as 10 to 15 percent of individuals checking into hospitals say they have had a previous reaction to penicillin, but when skin tests to determine allergy are conducted, only one fourth or less actually are allergic.

This doesn't mean they did not once have an allergic reaction to the antibiotic. It means that the allergy has faded away with the passage of time, and it is now safe to administer the drug that fights bacterial infection.

In the report, N. Franklin Adkinson, Jr., M.D., of the John Hopkins University School of Medicine, Baltimore, tells of a study that sought to find when some individuals lose their allergy to penicillin.

Dr. Adkinson reports that he learned some facts about the speed at which penicillin allergy regresses, but could not find out why it happens.

Another study by Bernard Levine, M.D., of New York University, indicates that up to 90 percent of persons with histories of penicillin allergy have negative results when skin-tested.

Meetings

"Antibiotic Review — 1981": August 10-11, Sheraton Washington Hotel, Washington, D.C. This third national conference will review and encourage appropriate antibiotic usage in hospitals. For further information, please contact: Sandy McMillan, 67 Peachtree Park Dr., Suite 221-D, Atlanta, Ga. 30309.

"The Pediatric Approach to Common Hematological Problems": October 9-11, Ocean City, Maryland. Topics to be addressed include: anemia; bleeding disorders; ITP: diagnosis and management; and a potpourri of pediatric hematology. Approved for 11 credit hours, Category I. For further information, please contact: Office of Continuing Education, 720 Rutland Ave., Baltimore, Md. 21205.

"Exploring the Relationship between Conductive Hearing Loss and Auditory Processing/Language Learning Disorders": October 19-21. Sponsored by the University of Cincinnati Medical Center. For further information, please contact: Dorothy H. Air, Ph.D., Division of Audiology and Speech Pathology, 234 Goodman St., A-122, Cincinnati, Ohio 45267.

Psychiatry's credibility to be examined during 1980s

Psychiatry during the next decade will continue the trend toward rational and scientific directions and away from ideological positions, predicted Melvin Sabshin, M.D., Medical Director of the American Psychiatric Association.

Dr. Sabshin recently reviewed major trends during the 1960s and cited objectives for psychiatry in the next 10 years.

"The first objective is the early termination of psychiatry's identity crisis, which peaked during the middle 1970s," said Dr. Sabshin. "American psychiatry took a sharp zig-zag from the 1960s to the 1970s, creating a lack of confidence and questions of direction."

Among the recent positive changes Dr. Sabshin cited is the constriction of psychiatry to the medical concerns and conditions he believes to be more appropriately within its realm. The 1960s saw the peak extension of psychiatric borders to include social problems not considered within the limits of psychiatry by many other countries, he continued.

He characterized psychiatry of the 1960s as "very pragmatic, atheoretical, antiintellectual and antiscientific. It was involved in multisocial issues, occasionally taking stances on moral and theoretical questions with the implication that data, not really available, supported such positions.

According to Dr. Sabshin, such activities cost psychiatry credibility.

The 1970s brought about a rapid return to empiricism, rationalism, a marked weakening of ideological positions — whether based on biological, psychotherapeutic, or social viewpoints — and a rise in scientific approaches, he said. "The turmoil and confusion experienced in the field during this period has led to a new consensus toward a more medical and scientific approach, especially among young psychiatrists."

Dispensing with a tailspin

The prescription drug market has, at last, come out of a long nose dive which sent it plunging to all-time lows during a six-year period, beginning in 1973. Powered by an upturn in refills and new drugs, however, the 42nd annual prescription survey found that last year a 2% climb in dispensing by the nation's drugstores had been achieved.

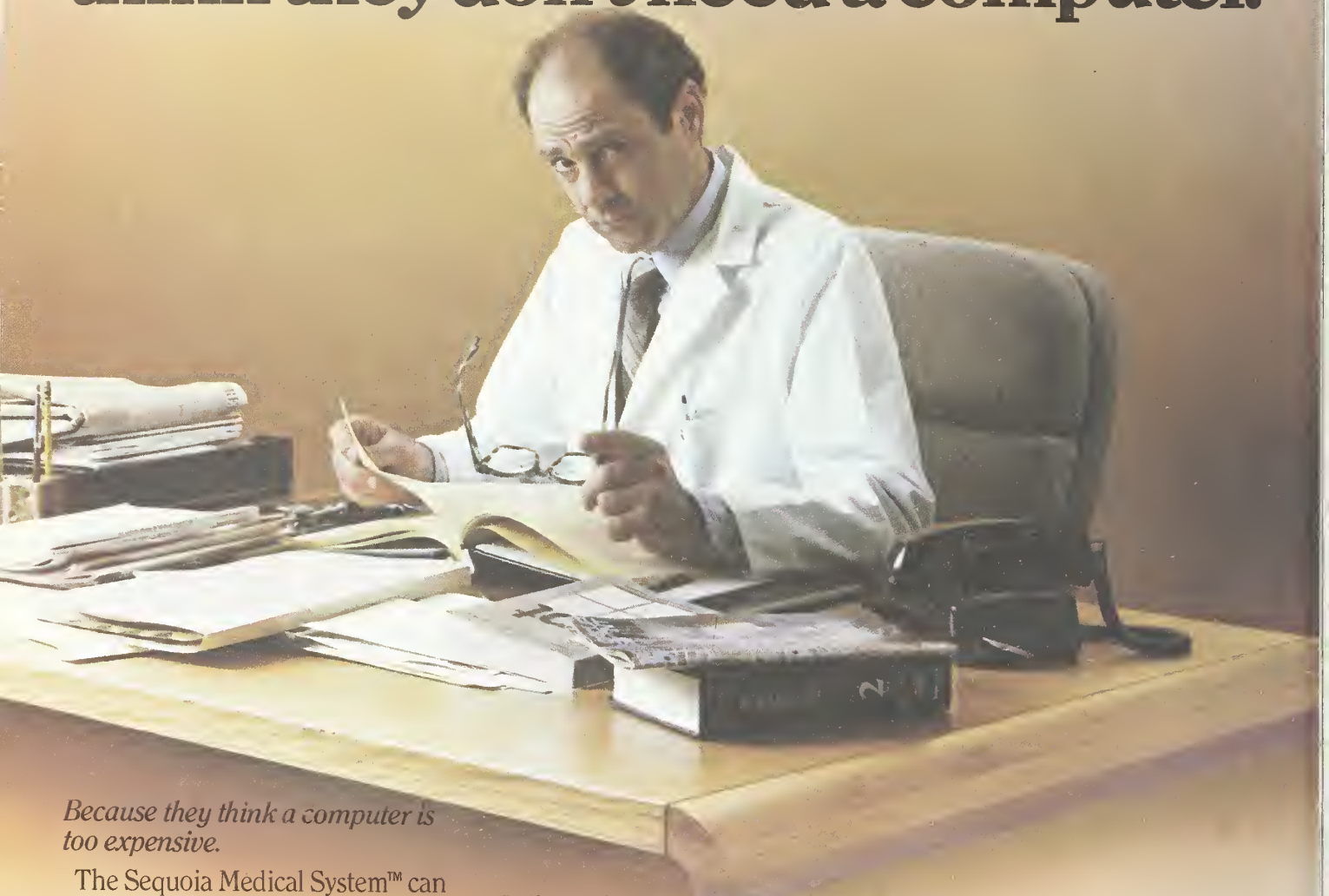
Partial reason for the upturn has been attributed to the "graying of America," since currently 23 million people are over the age of 65 in this country, and they take 2 1/2 times more medication than do younger people.

MISCELLANEA

• Network officials recently received letters from the American Medical Association, urging them to eliminate death-defying stunts from their programming. The letters stated that the use of dangerous stunts on television has brought a "new dimension" to television violence, and its effect on the viewing public. Not only are the stunt people sometimes injured or killed, but so are those who try to imitate the death-defying acts. The letters urged the networks to remove dangerous stunting from their production schedules "because the sensationalism of such stunts unavoidably encourages imitation.

• "Valuing a Medical Practice" is the name of a new booklet, recently published by the American Medical Association, to guide readers through the complex process of assessing the tangible and intangible elements that determine the worth of a practice. It covers assets from earnings and equipment to leases and goodwill. To order your copy, write the AMA Order Department, OP-117, P.O. Box 821, Monroe, Wisconsin 53566. Costs are: $5 for 1-10 copies, and $4.50 for 11-49. (A handling charge of $1.50 for orders of $10.99 or less, and $2 for orders of $11 or more should be added.)

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SECOND OPINION

JESSIE

By James F. Quilty, Jr., M.D.

Something occurred recently in a doctor's office which turned back the clock at least a generation in approaching treatment of mentally retarded persons. While hoping it was but an isolated event my intuition says such communication and its underlying thought processes are not uncommon. Let me share with you the event through the words of the mentally retarded child's father. You then can judge whether what transpired is appropriate communication.

Jessie (not the child's real name) is five years old. He is moderately to severely retarded. A younger brother functions normally. The parents are intelligent and informed. Because of their caring they attempt (successfully I might add) to involve Jessie in normal activities of childhood. One such activity is receiving quality medical services. Included under the aegis of this quality medical care is having birth defects corrected as well as possible so that the child — Jessie in this instance — maintains a healthy self-concept and achieves his optimum potential. Jessie's specific problem for which he is seeking care is strabismus. The father's words commence here:

"My kid's really pretty normal. He does a lot of the things that normal children do. His younger brother has already caught him developmentally in some areas. And we know he'll soon pass Jessie. We recently took Jessie to his eye doctor (an ophthalmologist). You see, Jessie has crossed eyes which detract from his appearance. After the doctor had given Jessie what I consider a very thorough examination the doctor said: 'Well since he'll (Jessie) probably be institutionalized, it's not worthwhile correcting his strabismus.' I was flabbergasted. I just could not even address the doctor at that time. He asked us to bring Jessie back in a couple weeks for a follow-up. My wife and I discussed the events and decided to see another eye doctor. No, we didn't confront the doctor; we thought we should have when we later thought about it, but, like I said, we were flabbergasted at the time.

"The doctor just didn't have a right to suggest that we put our child in an institution. We certainly want to talk about everything (in Jessie's life) and want the doctor's input, but the decision about what to do is ours. He (Jessie) is doing everything so well. We know he is never going to be normal but he is ours and we love him. I know this sounds corny but we feel very deeply about our child. We love him as much as our normal child."

The father stated his position succinctly and explained his feelings well. He is joined strongly by parents of all mentally retarded youngsters and adults. These parents want from the physician accurate diagnoses, understanding, and support. Possibly some parents still will want their child institutionalized; however, the vast majority of parents want, yes demand, to keep THEIR children in THEIR home as long as possible. In the case of many retarded persons that length of time represents a lifetime. Community-developed resources and Public Law 94-142 (the universal right to education) have provided the resources to make this possible.

If Jessie seeks your help please handle him and his family with honesty, care and understanding for there are several million Jessies in the United States. OSMA

"The doctor just didn't have a right to suggest that we put our child in an institution. We . . . want the doctor's input, but the decision about what we do is ours."

James F. Quilty, Jr., is the Chief of the Division of Maternal and Child Health for the Ohio Department of Health, and Assistant Professor of Pediatrics and Psychiatry, Ohio State University.

INDUSTRIAL ACCIDENTS: Finding the cause may help find the cure

By William W. Johnston

(Chairman of the Industrial Commission of Ohio)

The Division of Safety and Hygiene is a loss-prevention agency, offering safety assistance to all Ohio employers, free of charge.

Among the free services offered by the Division are annual statistical reports regarding lost-time industrial accidents in the State of Ohio. Each statistical packet contains information regarding the type of accident, the nature of the injury, the part(s) of the body injured, the cause of the accident, the age and sex of the injured employee, and the degree of the injury.

The Division hopes that by disseminating this information to industries, by revealing where past problems have existed, and giving Ohio employers a chance to rectify similar situations in their own areas of business — the incidence of industrial accidents in Ohio will decrease.

The following information is a sample of the information included in the Division's statistical report.

HIGHLIGHTS OF OHIO INDUSTRIAL ACCIDENTS FOR INJURIES TO UPPER EXTREMITIES[1] IN 1979

- A total of 38,741 upper extremity lost-time injuries[2] were filed with The Industrial Commission of Ohio during 1979. Thirty-eight percent of the workers with upper extremity lost-time injuries were in the 18-25 age group. One fourth (24.9 percent) were in the 26-35 age group, while another 13.9 percent were in the 36-45 age group.

- There were 1,558 disabilities involving amputation or loss of use. Disabling injuries involving over seven days of lost time numbered 24,162. Disabling injuries of less than seven days of lost time totaled 13,021.

- Thirty-one percent of the upper extremity lost-time injuries consisted of arm injuries, 18 percent consisted of hand injuries, and 51 percent consisted of finger injuries.

- Nearly one third of the upper extremity lost-time injuries were lacerations. Another 18.2 percent were fractures. Contusions totaled another 15.8 percent of the remaining injuries, while amputations constituted another four percent.

- Over one fourth (10,380) of the upper extremity lost-time injuries resulted from being caught in, on, or between objects, and averaged close to seven weeks of lost time per injury. Being struck by moving objects was the second leading type of accident, amounting to 9,144 injuries (23.6 percent), while another 21.2 percent (8,224 injuries) resulted from striking against objects.

- Men accounted for 29,744 injuries (76.8 percent), while women accounted for 8,997 injuries (23.2 percent).

- The predominant accident cause was machinery, responsible for 10,203 injuries (26.3 percent). Materials, especially metal stock, were responsible for 6,782 injuries (17.5 percent), while containers, furniture, and fixtures constituted another 11.2 percent (4,346 injuries).

- The 12,164 lost-time arm injuries resulted in 246,435 nonfatal days lost, an average of 20.3 days lost per injury. The 7,029 lost-time hand injuries accounted for 195,093 nonfatal days lost, an average of 27.8 days lost per injury, while the 19,548 lost-time finger injuries totaled 566,424 nonfatal days lost, an average of 29 days lost per injury.

- The preceding statistical information is based on lost-time claims filed during 1979. Cost information is not available on the lost-time claims filed during 1979 because many have not yet been adjudicated. However, cost information is available for allowed claims on upper extremity injuries which occurred from 1975 through 1978. For those claims for which data was available, the average compensation, medical benefits, and reserve[3] are presented in Tables 1 through 4.

- Payments were made for 102,893 upper extremity lost-time injuries from 1975 through 1978. The average total cost for each upper extremity[4] injury was $2,412[5]. The three costs which make up the total are: average compensation, $1,097; average medical benefits, $591; and average reserve, $724[5]. See Table 1.

- The average total cost of each disabling (loss of use) upper extremity[4] injury was $7,238 for the period from 1975 through 1978. The average total cost of each disabling hand-wrist injury was $36,475. The average total cost of each disabling finger injury was $5,927, while each disabling arm injury averaged $48,529.

- Average compensation paid out for each disabling upper extremity[4] injury was $3,709 for the period from 1975 through 1978. Each disabling hand-wrist injury averaged $19,191 in compensation. Disabling finger injuries averaged $3,017 in compensation, while disabling arm injuries averaged $24,919 in compensation.

- Average medical benefits paid out for each disabling upper extremity[4] injury was $1,763 for the period from 1975 through 1978. Each disabling hand-wrist injury averaged $7,340 in medical benefits. Disabling finger injuries averaged $1,517 in medical benefits, while disabling arm injuries averaged $8,151 in medical benefits.

- The average reserve for each disabling upper extremity[4] injury was $1,766 for the period from 1975 through 1978. Disabling hand-wrist reserves averaged $9,944. Each disabling finger injury reserve averaged $1,394, while disabling arm injury reserves averaged $15,460.

TABLE 1

Average Compensation, Medical Benefits, Reserve, and Total Cost of Upper Extremity[4] Injuries by Degree of Injury, 1975 through 1978

Degree of Injury	Average Compensation	Average Medical Benefits	Average Reserve[3]	Average Total Cost of Accident
Loss of Use	$3,709	$1,763	$1,766	$7,238
Over 7 Days	$ 842	$ 480	$ 624	$1,945
Average[5]	$1,097	$ 591	$ 724	$2,412

TABLE 2

Average Compensation, Medical Benefits, Reserve, and Total Cost of Hand-Wrist (Carpus) Injuries by Degree of Injury, 1975 through 1978

Degree of Injury	Average Compensation	Average Medical Benefits	Average Reserve[3]	Average Total Cost of Accident
Loss of Use	$19,191	$7,340	$9,944	$36,475
Over 7 Days	$ 904	$ 532	$ 764	$ 2,200
Average[5]	$ 1,257	$ 653	$ 928	$ 2,838

TABLE 3

Average Compensation, Medical Benefits, Reserve, and Total Cost of Finger Injuries by Degree of Injury, 1975 through 1978

Degree of Injury	Average Compensation	Average Medical Benefits	Average Reserve[3]	Average Total Cost of Accident
Loss of Use	$3,017	$1,517	$1,394	$5,927
Over 7 Days	$ 663	$ 412	$ 352	$1,426
Average[5]	$ 998	$ 570	$ 502	$2,070

TABLE 4

Average Compensation, Medical Benefits, Reserve, and Total Cost of Arm Injuries by Degree of Injury, 1975 through 1978

Degree of Injury	Average Compensation	Average Medical Benefits	Average Reserve[3]	Average Total Cost of Accident
Loss of Use	$24,919	$8,151	$15,460	$48,529
Over 7 Days	$ 1,197	$ 589	$ 1,120	$ 2,905
Average[5]	$ 1,216	$ 594	$ 1,131	$ 2,941

Notes:

[1]Upper Extremities include the following part of body codes: upper arm(s), elbow(s), forearm(s), wrist(s), arm(s)-unspecified, arm(s)-multiple parts, arm(s)-not elsewhere classified, carpal(s)-wrist, 1st metacarpal (thumb), 2nd metacarpal (index), 3rd metacarpal (middle), 4th metacarpal (ring), 5th metacarpal (little), palm(s), back of hand(s), hand(s)-general, thumb, index finger, middle finger, ring finger, little finger, thumb(s) and other(s), two or more fingers-not thumb(s), upper extremities-unspecified, upper extremities-multiple parts, and upper extremities-not elsewhere classified.

[2]The Research and Statistics Section of the Division of Safety and Hygiene, Industrial Commission of Ohio, records injuries which result in one or more days away from work as the data base for research.

[3]The average reserve is an average of costs and charges not yet paid, but anticipated to be paid, for similar claims.

[4]The average costs of upper extremity injuries are all weighted averages of the total hand-wrist, finger, and arm injuries.

[5]The column averages are weighted means of costs for the following degrees of injury: fatality, loss of use, over seven days lost time, and seven days or less lost time. For brevity, only injuries which have resulted in loss of use or over seven days lost are included in Tables 1 to 4.

The Auxilians' "Day at the Legislature"









Top left: Mrs. Rose Vesper, the Auxiliary's State Legislative Chairperson, and First Vice President addresses the group before they begin their tours. Top right and bottom left: The Auxilians learn the history of the State's House of Representatives Chamber. Bottom right: Several members of the group take a minute to study the riches inside the Statehouse Dome. All photos by Jennifer O'Brien, OSMA Legislative Staff.

A Management Seminar for Senior Residents

By J.D. McCue, M.D.; D.M. Waggoner, M.D.; and P.M. Holdorf, Ph.D.

Our fear that senior residents were given more responsibility for their interns' behavior than they were prepared for, led us to create a seminar in organizational and management techniques, specifically designed to meet the authoritative roles which these residents had assumed.

Organization of the Seminar

There were four parts to the seminar:

1. **Background reading.** A short collection of articles and chapters from books on management techniques was distributed to all participants two weeks in advance.

2. **Summary of seminar goals and discussion of reading material.** The stated intent was to provide managerial techniques designed to help senior residents handle problems on the ward. The roles of each member of the "team" would be defined, and differences in role perceptions would be negotiated among seminar participants. Finally, feedback techniques would be discussed and practiced though we believe that someone knowledgeable in management techniques is needed to discuss these concepts.

A. **The team concept.** The complexity of medical illness and treatment requires that the modern physician supplement his personal clinical abilities with the talents of other physicians, nurses, ancillary personnel, pharmacists, the patient's family, government programs, and community resources to effect change in the patient's life and illness. It is increasingly difficult for the physician working alone to meet the patient's needs and expectations. Whether private physicians recognize it or not, most function as the manager of a large team.

Residents are accustomed to being evaluated and rewarded as individuals; good managers, on the other hand, are rewarded on the basis of the performance of their team. Encouragement of productive activity and correction of ineffective, counterproductive behavior become central to the manager's role.

"Whether private physicians recognize it or not, most function as the manager of a large team."

B. **Conflict management.** Most conflicts on the ward can be reduced to role disagreements. Role **expectations** of each team member must be described by the team members and the manager ("My job consists of. . .; I think your job responsibilities are. . ."). After the **conflicts** among the different expectations are identified, a solution is **negotiated** which is acceptable to all parties. A new contract then is implemented or an old one reinforced.

C. **Recognizing when your team is in trouble** (pinch and crunch points). Unhappiness or nonproductive behavior in the team produces a "pinch point" — a good manager initiates role negotiation at this time. A "crunch point" is reached when the system breaks down, resulting in anxiety, forced negotiation, and resentful or forced termination. Pinches and crunches can be from internal problems, such as when a senior resident changes his expectations of interns, or external ones, such as when there is a change in residents.

D. **Positive and negative feedback.** The intent of feedback must be **helpfulness,** so it can be given in an ambience of trust and goodwill. The

manager **objectively** describes his perception of the situation and discusses **specific** problems or accomplishments. **Timeliness** is important. The person receiving the feedback should be in a position to do something about it.

When a team member is approached with the aim of helping him, the criticism or praise is fair, the events being discussed are recent or immediate, and the matters are specific rather than generalities, feedback usually will accomplish the goals of helping team members fulfill their role contracts.

3. **Role definition.** Tables 1-4 give some examples of role expectations of the seminar participants.

TABLE 1. What Interns Expect of Themselves

1. A history, physical, and a rudimentary assessment and plan.
2. Maintain the patient.
3. Coordinate patient care with other house officers.
4. Record necessary information in the patient's chart.
5. Competence and maturity.

TABLE 2. What Senior Residents Expect of Interns

1. A history, physical, and the initial laboratory data, recorded within 24 hours.
2. Primary responsibility for patient care including all acute events.
3. Communicate plans and negotiate medical decisions with patients.
4. Punctuality in attending ward functions and rounds.
5. Get the "scut" done without complaints.

TABLE 3. What the Intern* Expects of the Senior Resident

1. An assessment, plan and teaching for each patient.
2. Effective positive feedback and compassionate negative feedback.
3. Recognition of the intern's limitations, especially in regard to "scut."
4. Protection from unnecessary work.
5. Negotiate problems with nurses, faculty, and the chief.
6. Strive for team success, not personal glorification.

TABLE 4. What the Faculty Expects of Senior Residents

1. Final clinical decisions, incorporating consultant opinions.
2. Regular review of patient care for quality assurance.
3. Supervise and teach interns and students.
4. Help the faculty to evaluate interns and students.
5. Identification of team problems, and an attempt to solve them.
6. Foster a team approach with nurses and ancillary services and maintain morale.
7. Provide a role model.

The similarities in role descriptions, the interdependence, and the mutual respect implied by the high expectations of each other should make productive negotiations possible.

4. **Practicing conflict management and giving feedback.** Senior residents were asked to use the techniques discussed earlier to resolve some hypothetical conflicts with an intern-proxy. Each situation was one which a senior resident had actually been forced to handle on the ward.

Case I

Resident: 'Jack, I'm concerned that you're not getting your work done. Also, you are always late for rounds, which slows down the rest of us."

Intern: "I'm not happy here and I don't get any pleasure out of my work. All the patients are from nursing homes, I'm tired all the time, and you are always on my back trying to get me to do more scut work. Nobody tells me I'm doing a good job."

Case II

Intern: "Bill, there is just too much work to do. I get home at midnight on my night off, I have 15 patients in the hospital, and you never offer to help. You just fire questions at me and try to make me work harder."

Resident: "I'm limited by our hospital's obligations to the community — I can't refuse admissions. Eventually, the load will even out."

These real-life conflicts point out shortcomings on both sides — inefficiency and nonproductive behavior by interns, and poor feedback and management of intern workloads by the senior residents. The residents recognized that poor intern work performance can often be laid at the feet of the resident who is not managing his team well. Resolving these conflicts in the seminar was a powerful teaching tool. Acting out conflicts made the group acutely aware of how important feedback and conflict management techniques are.

Conclusion

The managerial demands made on senior residents are unique in his medical education and he is, in general, unprepared for them. His role requires skills in conflict management, role negotiation, quality assurance, teaching, and the integration of many medical and paramedical resources into patient care.

**Interns were represented by intern-proxy senior residents.*

J.D. McCue is the assistant professor of medicine at Case Western Reserve University, and practices at Cleveland Metropolitan General Hospital in Cleveland.

Highlights of the 1981 AMA Annual Meeting

May 16 - May 20

Sunday

Home-town radio interviews were conducted by OSMA's Department of Communications . . .



WNCI (Columbus) morning radio personality, John Corby, conducts an interview with Leonard Rome, M.D., Cleveland, which is taped and later sent to Dr. Rome's home-town radio station for later air-play.



John Corby and John Ray, M.D. Zanesville, discuss how consumers can help reduce the cost of medical care during their "home-town radio interviews."

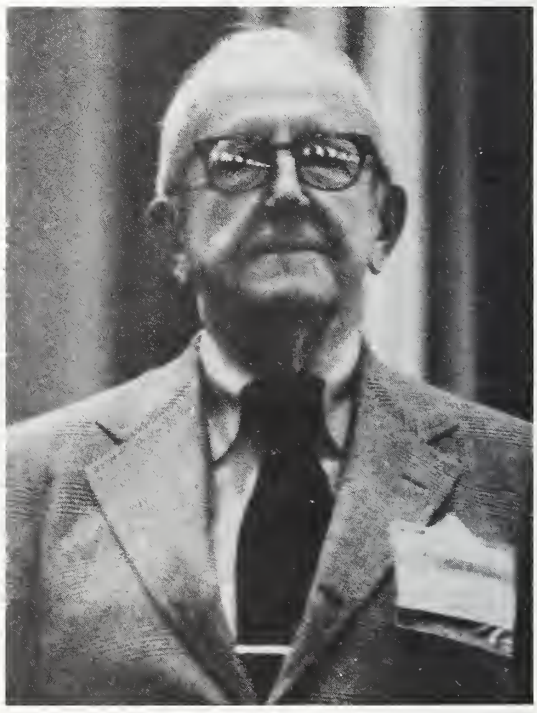
Sunday night

The OSMA presented its Distinguished Service Award to Charles L. Hudson, M.D.

Dr. Hudson has been serving patients and the practice of medicine for over 50 years. In addition to his past record as President of the Cuyahoga County Medical Association, the Ohio State Medical Association, and the American Medical Association, Dr. Hudson has served on numerous committees, including service on the Council of the World Medical Association.

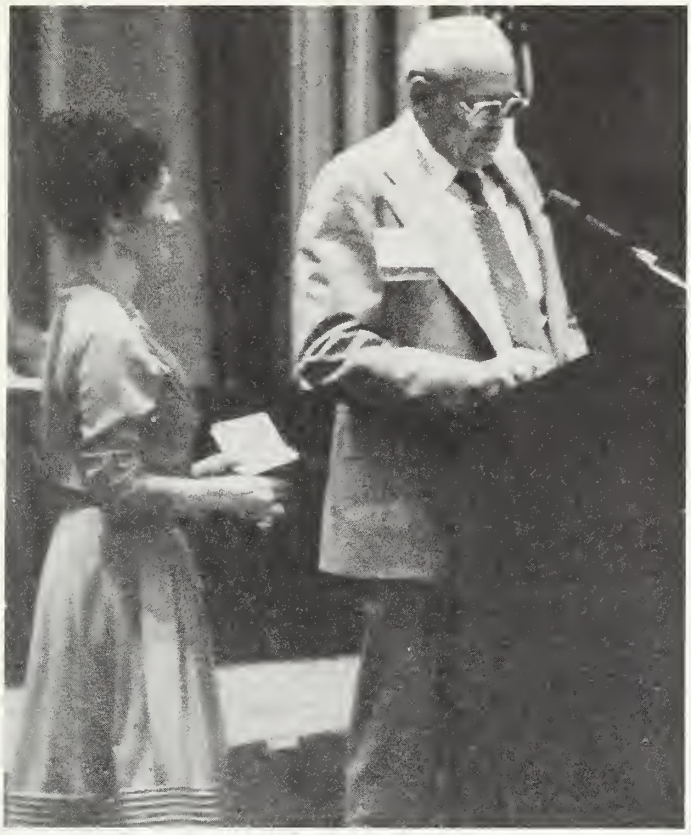


John Budd, M.D., Cleveland, presents the resolution that recommends the OSMA's Distinguished Service Award be presented to Dr. Hudson. Both Dr. and Mrs. Hudson look on.



Charles L. Hudson, M.D. . . .
a very distinguished colleague

There was other business to conduct at this Opening Session of the House of Delegates . . .



Philip Hardyman, M.D., and Auxiliary President Sarah Sato, distributed the AMA-ERF checks.



George Bates, M.D., presented the report on the current status of the Physicians Insurance Company of Ohio, and took the opportunity to announce his retirement as that company's chairman of the board.



President Robert A. Thomas, M.D., presented his presidential address.

Monday

Competition proved to be Monday's key word . . .



Roger Blackwell, Ph.D., (right) and Wesley Johnston, Ph.D., both of Ohio State University, presented a seminar on "Marketing and Competition" based on material gathered during several "Focus Group Interviews" which were conducted with a number of OSMA members throughout the state. Blackwell and Johnston offered some valuable insight into the world of competition.



Meanwhile, at Cleveland's Hollenden House, members of the OSMA Auxiliary were attending a fashion show, featuring fashions designed by OSMA member, S. Russell Trusso, D.O., Cleveland.

Tuesday

It was a day for continuing education courses and reference committee hearings . . . for the OMPAC Luncheon . . . and for the Annual Social Function.



The reference committees listened to discussions of resolutions which would be considered by the House at its closing session. From left to right: Stanley J. Lucas, M.D., Cincinnati, R. William Barry, M.D., Xenia, Robert M. Zollinger, M.D., Cleveland, chairman of Reference Committee No. 3, and Robert P. McFarland, M.D., Oberlin.



Entrants in the Journal's photo contest were on exhibit during the Annual meeting.

Wednesday Night

A new president . . . a past president . . . and a president-elect. Orders of business at the closing session.



Oscar Clarke, M.D., presented Mrs. Vera Kalnins, Bucyrus, with the "Best in Show" plaque for her winning entry, "The Boat," in the Journal's Photographic Exhibit contest.



C. Douglass Ford, M.D., joins the podium after being unanimously elected as OSMA's new President-Elect.

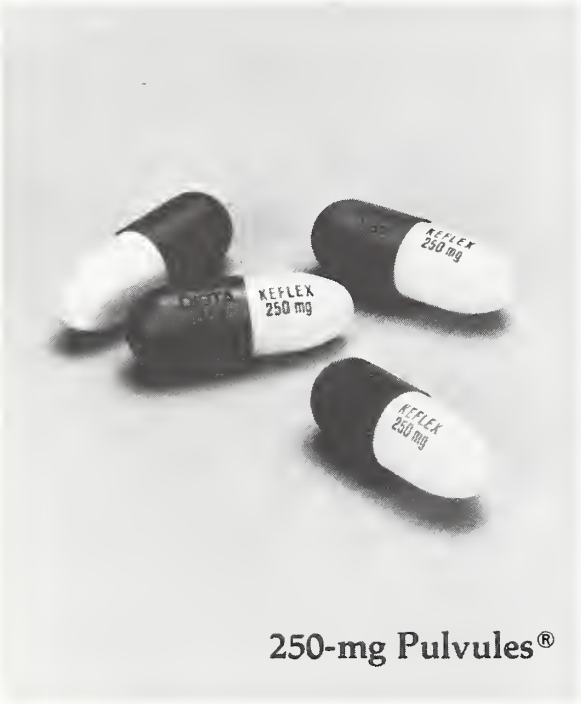


Stewart Dunsker, M.D., addresses the House of Delegates as OSMA's new President. (Left to right) Hart Page, OSMA Executive Director, Thomas Morgan M.D., OSMA Past President, and C. Douglass Ford, M.D., President-Elect look on.



"These are the women in my life," Dr. Dunsker said, as he introduced his wife, Ellen, and daughter, Sheila, to the House.

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INDEX TO ACTIONS ON RESOLUTIONS

Editor's Note: Report of Resolutions Committee No. 1 begins on page 433; Resolutions Committee No. 2 on page 437; Resolutions Committee No. 3 on page 439. This index is for reference purposes and is not part of the Official Proceedings of the 1981 House of Delegates.

RESOLUTION NO . . .	SUBJECT AND SPONSOR	REFERRED TO RESOLUTIONS COMMITTEE
01-81	**To Amend the OSMA Constitution and Bylaws to Create a Medical Student Business Section and to Provide for the Selection of Representatives of the Medical Student Business Section to the House of Delegates** (By OSMA Council)	1
02-81	**Voting Membership for Medical Students** (By Fifth District Delegation)	1
03-81	**Organizational Structure of the OSMA** (By Fifth District Delegation)	1
04-81	**Specialty Society Representation** (By Robert S. Heidt, M.D., President-Elect, the Ohio Orthopaedic Society)	1
05-81	**Specialty Society Representation in OSMA** (By First District Delegation)	1
06-81	**Physician for Office of OSMA Executive Vice President** (By Huron County Medical Society)	1
07-81	**Election of Officers** (By Second Councilor District)	1
08-81	**Direct Election of District Councilors** (By Wood County, Putnam County and Henry County Medical Societies)	1
09-81	**Privilege of the Floor of the House for Past Councilors** (By Fifth District Delegation)	1
10-81	**Reduction of Dues at Age 70** (By Summit County Medical Society)	1
11-81	**Resolutions Screening Committee** (By Alford C. Diller, M.D., Third District Councilor)	1
12-81	**Ohio State Medical Association Annual Meeting** (By Thomas R. Leech, M.D., Alternate, Allen County; Ronald Berggren, M.D., Alternate, Franklin County; A. Robert Davies, M.D., Delegate, Miami County; William Dorner, Jr., M.D., Twelfth District Councilor, Summit County; A. Burney Huff, M.D., Delegate, Wayne County; Christopher Kircher, M.D., Member, Hamilton County; Leonard P. Rome, M.D., Delegate, Cuyahoga County; Leonard K. Smith, M.D., Alternate, Hardin County; James W. Wiggin, M.D., Delegate, Richland County)	1
13-81	**Needed Physician Support for Neonatal Nurses** (By Gerald H. Katzman, M.D., Member, Academy of Medicine of Toledo and Lucas County)	1
14-81	**The Ohio State Medical Journal** (By Board of Trustees, Stark County Medical Society)	1
15-81	**Women in Medicine** (By Fifth District Delegation)	1
16-81	**Comprehensive Placement Service** (By Alford C. Diller, M.D., Third District Councilor)	1
17-81	**Huron County Medical Society Requests OSMA Medical Legal Fund Assistance** (By Huron County Medical Society)	1
18-81	**Legal Defense Fund Assistance to Northwest Ohio Small Hospitals (Law Firm of Eckler & Bricker-Columbus, Ohio)** (By Huron County Medical Society)	1
19-81	**Federal Regionalism** (By Huron County Medical Society)	1
20-81	**Special Commendation to the OSMA Delegation to the AMA** (By Fifth District Delegation)	2
21-81	**Immediate Implementation of 1979 Approved Report G of the AMA House of Delegates** (By Felino V. Barnes, M.D., Delegate, Cuyahoga County)	2
22-81	**Continued Support by OSMA and County Societies of the AAMA-OSS** (By Alford C. Diller, M.D., Third District Councilor and Advisor to the AAMA-OSS)	2
23-81	**Reconvene Task Force on Professional Liability** (By Academy of Medicine of Toledo and Lucas County)	2
24-81	**Malpractice Insurance Rates** (By Second Councilor District)	2
25-81	**Membership Dues Refund** (By Fifth District Delegation)	2
26-81	**Assignment of Health Insurance Benefits** (By Fifth District Delegation)	2
27-81	**Prompt Payment of Insurance Claims** (By Fifth District Delegation)	2
28-81	**Interest Payments on Overdue Accounts** (By Fifth District Delegation)	2
29-81	**The Right of a Hospitalized Patient to Choose His Attending or Consulting Physician** (By Fifth District Delegation)	2
30-81	**Amendment Process of Medical Staff Bylaws** (By Fifth District Delegation)	2
31-81	**Organized Medicine Participation with Business Leaders** (By Alford C. Diller, M.D., Third District Councilor)	2
32-81	**Ohio Medical Hall of Fame** (By Huron County Medical Society)	2
33-81	**Freedom of Choice in Medical Care** (By Huron County Medical Society)	2
34-81	**Repeal P.S.R.O.** (By Huron County Medical Society)	3
35-81	**Repeal P.S.R.O.** (By Seneca County Medical Society)	3
36-81	**Congratulations OSMA-California Delegations** (By Huron County Medical Society)	3
37-81	**Immunity to Civil Liability for Communications to Peer Review Committees** (By Edward G. Kilroy, M.D., Fifth District Councilor)	3
38-81	**Peer Review Organizations** (By Paul Jones, M.D., Member, Muskingum County)	3
39-81	**Continuing Medical Education** (By Summit County Medical Society)	3
40-81	**Continuing Medical Education** (By Mahoning County Medical Society)	3
41-81	**Abolition of Continuing Medical Education for Relicensure** (By Butler County Medical Society)	3
42-81	**Opposition to Present Attempts to Change the Requirements for a Medical Certificate to Practice Medicine in Ohio** (By Summit County Medical Society)	3
43-81	**Change in the Ohio Medical Licensure Law** (By Wood County Medical Society)	3
44-81	**Appropriateness Review of Emergency Rooms** (By Academy of Medicine of Cleveland)	3

45-81	**Welfare Payment Inequities** (By Mahoning County Medical Society)	3
46-81	**Statewide Prevailing Area for Third-Party Reimbursement in Ohio** (By Defiance County Medical Society and the Williams County Medical Society)	3
47-81	**Manpower** (By Second Councilor District)	3
48-81	**Resolution Regarding Physician Surplus and State of Ohio Medical School Enrollment** (By Hardin County Medical Society)	3
49-81	**Abolition of Mandatory Premarital Serology Testing** (By Fifth District Delegation)	3
50-81	**"PAP SMEAR" Law** (By Fifth District Delegation)	3
51-81	**Resolution to Teach Bio-Ethics in Ohio Medical Schools** (By Fifth District Delegation)	3
52-81	**Comprehensive Health Education in Ohio Schools** (By Fifth District Delegation)	3
53-81	**Confidentiality of Quality Assurance Program Information** (By First District Delegation)	3
54-81	**Voluntary Health Planning at the Local Level** (By Academy of Medicine of Columbus and Franklin County)	3
55-81	**Tax Treatment and Catastrophic Health Insurance** (By Huron County Medical Society)	3
56-81	**Catastrophic Health Insurance** (By Huron County Medical Society)	3
57-81	**N.W. Ohio Hospitals vs. The Health Planning Association of N.W. Ohio** (By Huron County Medical Society)	3

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PROCEEDINGS OF THE 1981 ANNUAL MEETING OF THE OSMA HOUSE OF DELEGATES

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7 PM, Sunday, May 17, 1981, at Stouffer's Inn on the Square, Cleveland, with President Robert G. Thomas, M.D., presiding. The session opened with a four-man color guard provided by the Ninth Coast Guard District, Cleveland, followed by the Pledge of Allegiance led by Dr. Thomas.

The invocation was offered by Rabbi Howard A. Simon, K.K. Bene Israel/Rockdale Temple, Cincinnati.

Dr. Thomas introduced James L. Golden, Ph.D., Director of Communications, The Ohio State University, the parliamentarian retained in accordance with Resolution No. 1-76.

Dr. Robert M. Zollinger, Jr., Cleveland, President of the Academy of Medicine of Cleveland, welcomed the delegates and guests to Cleveland.

REPORT ON DELEGATES PRESENT

Dr. Luther W. High, Millersburg, Chairman of the Credentials Committee, reported that of 188 members eligible to attend and vote, 140 were present, credentialed and seated. A number of alternate delegates, guests, officers of county medical societies, and executives were in attendance.

1980 MINUTES APPROVED

The minutes of the 1980 sessions of the House of Delegates, as published in the July 1980 issue of *The Ohio State Medical Journal, were approved* by official action.

INTRODUCTION OF AMA BOARD OF TRUSTEES MEMBER

Dr. Thomas then introduced Dr. William S. Hotchkiss, Norfolk, Virginia, Secretary-Treasurer, Board of Trustees of the American Medical Association. Dr. Hotchkiss addressed the House.

INTRODUCTION OF OUT-OF-STATE GUESTS

Dr. Thomas introduced Dr. L. Walter Fix, Martinsburg, West Virginia, President of the West Virginia State Medical Association, and Dr. Alvin J. Haley, Carmel, Indiana, President, Indiana State Medical Association.

INTRODUCTION OF REPRESENTATIVES OF ALLIED ORGANIZATIONS

Dr. Thomas introduced the following representatives of allied organizations: Dr. Don Shumaker, President-Elect, Ohio Dental Association; James C. Brown, Chairman of the Board, Ohio Hospital Association; Mrs. Gail Bromelmeier, Executive Director, Greater Cleveland Nurses Association, representing the Ohio Nurses Association; Dr. Tennyson Williams, President-Elect, Ohio Academy of Family Physicians; Mrs. Sam I. Sato, President, and Mrs. A. Robert Davies, President-Elect, Ohio State Medical Association Auxiliary; Ms. Dorothy Belsterli, President, Ohio State Society of Medical Assistants (who was not present) and two medical students: John L. Buker, Medical College of Ohio at Toledo and Benjamin Signer, University of Cincinnati College of Medicine.

INTRODUCTION OF OSMA PAST PRESIDENTS

The following past presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. Charles L. Hudson, Bratenahl; Dr. Frank H. Mayfield, Cincinnati; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. Oscar W. Clarke, Gallipolis; Dr. James L. Henry, Grove City; Dr. George N. Bates, Toledo; Dr. William M. Wells, Newark; Dr. John J. Gaughan, Cleveland; and Dr. Thomas W. Morgan, Gallipolis.

INTRODUCTION OF PAST MEMBERS OF THE OSMA COUNCIL

Dr. Thomas then introduced former members of the Council: Dr. Theodore J. Castele, Cleveland; Dr. Philip B. Hardymon, Columbus; Dr. Stephen P. Hogg, Cincinnati; Dr. W. J. Lewis, Dayton; Dr. C. Edward Pichette, Youngstown; and Dr. Edwin R. Westbrook, Warren.

OTHER GUESTS INTRODUCED

Dr. Thomas introduced the following: Dr. John H. Ackerman, Columbus, Director, Ohio Department of Health; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; and Dr. W. J. Lewis, Dayton, Member of the Board of Trustees, American Medical Association.

PICO REPORT

Dr. Thomas then introduced Dr. George N. Bates, Toledo, Chairman of the Board of Trustees, Physicians Insurance Company of Ohio. Dr. Bates gave a report on the current status of the company and a summary of the activities and accomplishments of PICO in 1980.

REPORT OF OSMA AUXILIARY PRESIDENT

Mrs. Sarah N. Sato, Willoughby, President of the Ohio State Medical Association Auxiliary, was escorted to the podium by Dr. S. Baird Pfahl, Sandusky, OSMA Eleventh District Councilor. She addressed the House of Delegates and reported on 1980 activities of the Auxiliary.

PRESENTATION OF THE OSMA 1981 DISTINGUISHED SERVICE AWARD

Dr. John H. Budd, OSMA Honorary President, escorted Dr. and Mrs. Charles L. Hudson, Bratenahl, to the podium and presented Dr. Hudson with a plaque and read the following resolution:

WHEREAS, Charles L. Hudson, M.D., has distinguished himself in his service to medicine and his fellow physicians; and

WHEREAS, Dr. Hudson, through his inspired leadership as President of the American Medical Association, was able to guide the Association through difficult and challenging times; and

WHEREAS, Dr. Hudson served with distinction as President of the Ohio State Medical Association; and

WHEREAS, Dr. Hudson continues in his role as a senior statesman by remaining very active in organized medicine on

local, state and national levels; now therefore be it

RESOLVED, That the Ohio State Medical Association expresses its deepest respect and gratitude to Dr. Hudson for his leadership and continued service to medicine.

The resolution passed unanimously and Dr. Hudson received a standing ovation.

Dr. Hudson addressed the House and expressed his thanks and appreciation.

AMA-ERF CHECKS PRESENTED

Dr. Philip B. Hardymon, Columbus, Chairman of Ohio's Committee for the American Medical Association's Education and Research Foundation (AMA-ERF) was introduced, as was Mrs. Sarah N. Sato, President of the OSMA Auxiliary. Mrs. Sato assisted Dr. Hardymon in the presentation of the AMA-ERF checks to Ohio's six medical schools.

It was announced that these contributions totalled $59,328.86. Dr. Thomas expressed thanks on behalf of the Association to Dr. Hardymon and to the OSMA Auxiliary.

CERTIFICATES OF APPRECIATION

Mrs. Joan Fulton, escorted to the podium by Dr. Oscar W. Clarke, Gallipolis, Chairman of the AMA Delegation, accepted a certificate of appreciation awarded posthumously to Dr. Richard L. Fulton, who served on the Ohio Delegation to the AMA.

Mrs. Fulton addressed the House and the members of the House stood in tribute to Dr. Fulton.

Dr. Thomas W. Morgan, Gallipolis, Dr. J. Hutchison Williams, Columbus, and Dr. William Dorner, Jr., Akron, received plaques in appreciation of their service to the Association as retiring members of the Council.

The following members of Standing Committees and chairmen of Special Committees received certificates of appreciation:

Dr. Robert E. Reiheld, Orrville, Member, Committee on Communications and Committee on Judicial and Professional Relations; Dr. Leonard P. Rome, Cleveland, Member, Committee on Communications; Dr. J. Craig Strafford, Gallipolis, Member, Committee on Program; Dr. Ernest W. Johnson, Columbus, Chairman, Committee on Rehabilitation; Dr. Ray W. Gifford, Cleveland, Chairman, Federal Legislative Liaison Committee; Dr. Daniel M. Murphy, Marion, Chairman, Committee on Workmen's Compensation; Dr. William Hawk, Cleveland, Chairman, Committee on Laboratory Medicine; Dr. A. Burton Payne, Ironton, Chairman, Task Force on Medical Licensure and Enforcement; Dr. Robert L. Willard, Toledo, Chairman, Committee on Eye Care; Dr. Robert M. Craig, Dayton, Chairman, Joint Officers Committee; Dr. William Dorner, Jr., Akron, Chairman, Medical Services Review Committee; Dr. C. Douglass Ford, Toledo, Chairman, Committee on Auditing and Appropriations; Dr. S. Baird Pfahl, Jr., Sandusky, Chairman, Committee on Cost Effectiveness; Dr. A. Robert Davies, Dayton, Chairman, Committee to Explore Negotiations Process; Dr. Luther W. High, Millersburg, Chairman, Committee on Public Relations and Economics.

REFERENCE COMMITTEES APPOINTED

The following House of Delegates Reference Committee chairmen were introduced by the President:

Credentials of Delegates — Dr. Luther W. High, Holmes County; Tellers and Judges of Election — Dr. Thomas Leech, Allen County; President's Address — Dr. James W. Wiggin, Richland County; Resolutions Committee No. 1 — Dr. Paul S. Metzger, Franklin County; Resolutions Committee No. 2 — Dr. Joseph Sudimack, Jr., Trumbull County; Resolutions Committee No. 3 — Dr. Robert M. Zollinger, Jr., Cuyahoga County.

ELECTION OF COMMITTEE ON NOMINATIONS

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: First District — Dr. Robert S. Heidt, Hamilton County; Second District — Dr. A. Robert Davies, Miami County; Third District — Dr. David W. Nielsen, Auglaize County; Fourth District — Dr. Thomas J. O'Grady, Lucas County; Fifth District — Dr. John J. Gaughan, Cuyahoga County; Sixth District — Dr. Raymond J. McMahon, Stark County; Seventh District — Dr. Carl A. Lincke, Carroll County; Eighth District — Dr. John P. Anderson, Jr., Licking County; Ninth District — Dr. Richard Villarreal, Scioto County; Tenth District — Dr. H. William Porterfield, Franklin County; Eleventh District — Dr. James R. Hart, Erie County; Twelfth District — Dr. Paul D. Gatewood, Summit County.

Dr. Thomas announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the Eighth District, Dr. John P. Anderson, Jr., Licking County.

INTRODUCTION OF MEMORIAL RESOLUTION

The following memorial resolution was introduced by Dr. George W. Paulson, Columbus, on behalf of the Academy of Medicine of Columbus and Franklin County:

WHEREAS, Richard L. Fulton, M.D., Columbus Ohio, died on December 20, 1980; and

WHEREAS, Dr. Fulton served as President of the Academy of Medicine of Columbus and Franklin County and President of the Ohio State Medical Association; and

WHEREAS, Dr. Fulton was named one of the *Citizen-Journal's* top ten men of the year in 1962 as a result of his chairmanship of the "Sabin on Sunday" mass polio immunization program; and

WHEREAS, Dr. Fulton served as President of the Central Ohio Diabetes Association; and

WHEREAS, Dr. Fulton served his community faithfully and well during his thirty years as a physician specializing in Internal Medicine; and

WHEREAS, Dr. Fulton served as an Alternate Delegate to the American Medical Association and a Delegate to the American Medical Association; and

WHEREAS, Dr. Fulton exemplified the highest tradition of medicine in his service to his patients, to his community and to the medical profession; therefore be it

RESOLVED, That the Ohio State Medical Association expresses its sincere appreciation and admiration for Dr. Fulton's many contributions during his lifetime and extends its deepest sympathy to Joan Fulton and her family.

The resolution was adopted by a standing vote of the members of the House of Delegates.

INTRODUCTION OF RESOLUTIONS

Dr. Thomas announced that because the resolutions had been printed and distributed prior to the meeting and the assignment of resolutions to the Resolutions Committees had also been presented to the House in writing, individual introduction would be waived unless there were objections voiced by the House. There were none and the reading of the Resolutions was waived.

COMMITTEE ON EMERGENCY RESOLUTIONS REPORT

The Committee on Emergency Resolutions, consisting of the chairmen of the three resolutions committees, met earlier on May 17 to consider five emergency resolutions.

Dr. Metzger, as chairman of the committee, presented the report to the House of Delegates.

Four resolutions approved for submission to the House were:

58-81 — Direct Membership in the AMA
59-81 — Restructure of the AMA
60-81 — Hospital Malpractice Insurance
61-81 — Resolution on FTC

The report was filed by action of the House.

The resolutions were referred to the Resolutions Committees as follows: 58-81 to Resolutions Committee No. 1; 59-81 to Resolutions Committee No. 1; 60-81 to Resolutions Committee No. 2; and 61-81 to Resolutions Committee No. 3.

PRESIDENT'S ADDRESS

Mr. Page then introduced President

Robert G. Thomas, Elyria, who delivered his Presidential Address.

Dr. Thomas received a standing ovation.

Before going on with the additional business of the House, Dr. Thomas introduced Hart F. Page, CAE, Executive Director of the Association, and commended him on his 35-years' service to the OSMA. He presented Mr. Page with gifts from the Council and the Staff.

Mr. Page addressed the House and expressed his thanks.

ACTION REPORT ON 1980 RESOLUTIONS

Dr. Thomas announced that a report on the "follow-up" work on 1980 Resolutions had been distributed to the Delegates and Alternates prior to the First Session.

REPORT OF AD HOC COMMITTEE ON AMENDED RESOLUTION 19-79 UPDATE OF OSMA POLICY

Dr. Thomas introduced Dr. Richard J. Nowak, Cleveland, Member of the Ad Hoc Committee to Review OSMA House of Delegates Policy (Report A), who presented the following:

At the 1980 OSMA Annual Meeting, the House of Delegates adopted a comprehensive report that resulted from Resolution No. 19-79, Update of OSMA Policy. The OSMA House of Delegates had the option of extracting and delaying final action on any recommendation contained in the Ad Hoc Committee and Council's report. Following are the Resolutions that were extracted for reconsideration as well as current Ad Hoc Committee and Council recommendations:

I. Resolution No. 40-76, Determination of Death

Action recommended: The Committee and Council reaffirm the original recommendation that Resolution No. 40-76 not be retained as OSMA House of Delegates Policy.

II. Amended Substitute Resolution No. 30-77, Liability Reform

Action recommended: The Committee and Council recommend that Amended Substitute Resolution No. 30-77 be retained, reversing its original recommendation.

III. Substitute Resolution on Universal Immunizations, 1959

Action recommended: The Committee and Council recommend that Substitute Resolution on Universal Immunizations, 1959, be retained until a new immunization policy is established by the OSMA House of Delegates.

IV. Amended Resolution No. 19-74, Preadmission Certification

Action recommended: The Committee and Council recommend that Amended Resolution No. 19-74 be retained until a new preadmission certification policy is established by the OSMA House of Delegates.

V. Amended Resolution No. 42-76, Maximum Allowable Cost Regulations

Action recommended: The Committee and Council reaffirm the original recommendation that Resolution No. 42-76 be retained as OSMA House of Delegates Policy.

VI. Substitute Resolution No. 23-77, Cost Containment; Government Health Programs

Action recommended: The Committee and Council reaffirm the original recommendation that Substitute Resolution No. 23-77 be retained as OSMA House of Delegates Policy.

By official action, the House voted to approve the recommendations contained in the Report of the Ad Hoc Committee to Review OSMA House of Delegates Policy.

HOUSE RECESSED

The House then recessed until the final session, 3:30 PM, Wednesday, May 20.

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More physicians today realize what a tough problem we're all faced with. They know this is a challenge for medicine. And that physicians are in the best position to deal with and solve the problem.

*PATIENT CARE Magazine—Outlook 1977 "Face-Off: Cost Containment vs. Chaos," January 1, 1977.

Lyle CB, et al. "Practice habits in a group of eight internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al. "Use of laboratory tests and pharmaceuticals: variation among physicians and effect of cost audit on subsequent use," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 225 (Aug. 20, 1973), 969-73.

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OSMA's new president-elect

The Ohio State Medical Association is proud to welcome C. Douglass Ford, M.D., as the Association's new president-elect.

Dr. Ford, an internist from Toledo, has been an active member of the OSMA, AMA, and various groups for many years.

Born in Columbus, Ohio, Dr. Ford received his bachelor's degree from Wesleyan University in Middletown, Connecticut before entering New York Medical College in New York, New York.

Following his graduation in 1949, he went on to serve a rotating internship in the U.S. Army, then took his residency at Toledo Hospital before settling into private practice as an internist in the Toledo area.

As a member of Toledo Hospital's medical staff since 1955, Dr. Ford has served as vice chief of staff for four years, and has been director of the hospital's radioisotope laboratory for 25 years.

In addition to his practice and hospital duties, Dr. Ford is active in a number of community and medical organizations. He has served as clinical associate at the Medical College of Ohio for twelve years, and still serves on its Advisory Committee on Graduate Nursing Education. He is a member of the American Medical Association, the Society of Nuclear Medicine, the Ohio Society of Internal Medicine, the New York Academy of Sciences, and the Health Planning Association of Northwestern Ohio.

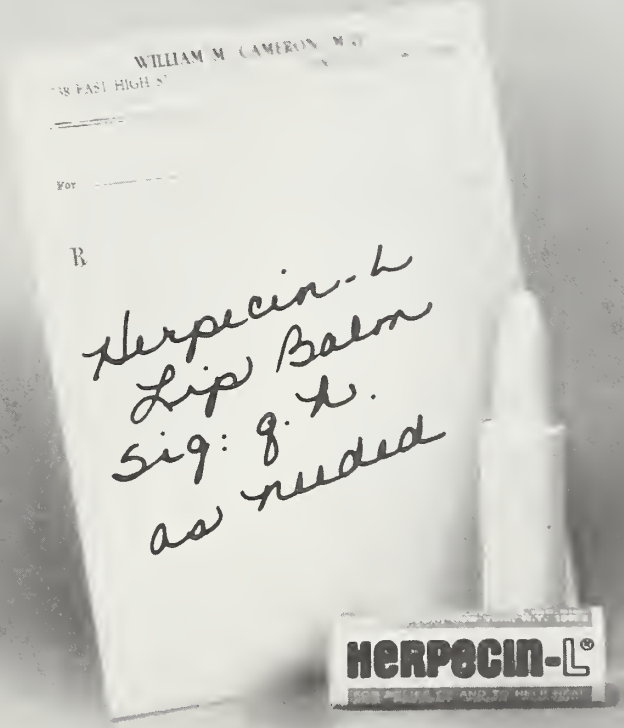
Dr. Ford is a past president of the American Heart Association of Northwestern Ohio, a former councilor of the Academy of Medicine of Toledo and Lucas County, and has served the Ohio State Medical Association in a number of capacities, including Councilor from the Fourth District, a post he held for six years.

He is married to the former Elizabeth (Betsy) Sargent, and has six children.



C. Douglass Ford, M.D.

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MINUTES OF THE SECOND SESSION OF THE HOUSE OF DELEGATES

The final business session of the House of Delegates was convened at 3:30 PM, Wednesday, May 20, at Stouffer's Inn on the Square, Cleveland, with President Robert G. Thomas, M.D., presiding.

PRESENTATION OF PHOTOGRAPHIC AWARDS

The 1981 Ohio State Medical Journal Photographic Exhibit awards were presented by Dr. Oscar W. Clarke, Gallipolis.

REPORT OF THE CREDENTIALS COMMITTEE

Dr. Luther W. High, Millersburg, Chairman of the Committee on Credentials, reported that out of 188 delegates eligible to vote, 151 were present, credentialed and seated.

ELECTION OF PRESIDENT-ELECT

Dr. Thomas called for nominations for the office of President-Elect.

Dr. George N. Bates, Toledo, placed in nomination Dr. C. Douglass Ford, Toledo, Lucas County. The nomination was seconded by Dr. Thomas Leech, Lima. There being no other nominations, Dr. Ford was unanimously elected.

REPORT OF NOMINATING COMMITTEE

Dr. John P. Anderson, Jr., Delegate, Licking County, Chairman of the Nominating Committee, presented the report of the Committee on Nominations as follows:

Councilor

Second District: As Councilor of the Second District to succeed himself, the Committee placed in nomination Dr. Herman I. Abromowitz, Dayton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Abromowitz was declared reelected Councilor of the Second District for a term of two years, 1981-1983.

Fourth District: As Councilor of the Fourth District to succeed Dr. C. Douglass Ford, the Committee placed in nomination Dr. Benjamin H. Reed, Jr., Delta. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Reed was declared elected Councilor of the Fourth District for a term of two years, 1981-1983.

Sixth District: As Councilor of the Sixth District to succeed himself, the Committee placed in nomination Dr. Joseph P. Yut, Canton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Yut was declared reelected Councilor of the Sixth District for a term of two years, 1981-1983.

Eighth District: As Councilor of the Eighth District to succeed himself, the Committee placed in nomination Dr. Carl E. Spragg, New Concord. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Spragg was declared reelected Councilor of the Eighth District for a term of two years, 1981-1983.

Tenth District: As Councilor of the Tenth District to succeed himself, the Committee placed in nomination Dr. D. James Hickson, Mt. Gilead. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Hickson was declared reelected Councilor of the Tenth District for a term of two years, 1981-1983.

Twelfth District: As Councilor of the Twelfth District to succeed Dr. William Dorner, Jr., the Committee placed in nomination Dr. Joseph L. Kloss, Akron. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Kloss was declared elected Councilor of the Twelfth District for a term of two years, 1981-1983.

AMA Delegates

Dr. Anderson then presented the nominees for the office of Delegate to the American Medical Association to fill a vacancy for a term beginning May 20, 1981 and ending December 31, 1981: Drs. B. Leslie Huffman, Jr., Maumee; and Robert G. Thomas, Elyria. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Dr. Huffman was declared elected.

The nominees for Delegate to the American Medical Association to serve a term beginning May 20, 1981 and ending December 31, 1982 were: Drs. Theodore J. Castele, Cleveland; and Robert G. Thomas, Elyria. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Dr. Castele was declared elected.

For Delegate to the American Medical Association to serve a two-year term beginning January 1, 1982 to December 31, 1983, the nominees were: Drs. John E. Albers, Cincinnati; George N. Bates, Toledo; Oscar W. Clarke, Gallipolis; John J. Gaughan, Cleveland; B. Leslie Huffman, Jr., Maumee; and Robert G. Thomas, Elyria. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Albers, Bates, Clarke, Gaughan and Huffman were declared elected.

AMA Alternates

For Alternate Delegate to the American Medical Association to fill a term beginning May 20, 1981 and ending December 31, 1981, the nominees were: Drs. Herman I. Abromowitz, Dayton; Felino V. Barnes, Cleveland; Ronald B. Berggren, Columbus; Thomas E. Fox, Mason; Roland A. Gandy, Jr., Toledo; Edward G. Kilroy, Cleveland; James E. Matson, Columbus; and Carl E. Spragg, New Concord. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Dr. Abromowitz was declared elected.

For Alternate Delegate to the American Medical Association to fill a term beginning January 1, 1982 and ending December 31, 1983, the nominees were: Drs. Herman I. Abromowitz, Dayton; Felino V. Barnes, Cleveland; Ronald B. Berggren, Columbus; William Dorner, Jr., Akron; C. Douglass Ford, Toledo; Thomas E. Fox, Mason; Roland A. Gandy, Jr., Toledo; Edward E. Grable, Canton; Thomas W. Morgan, Gallipolis; and Carl E. Spragg, New Concord. Dr. Edward G. Kilroy, Cleveland, was nominated from the floor. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Abromowitz, Dorner, Ford, Grable and Morgan were declared elected.

For Alternate Delegate to the American Medical Association to fill a term beginning May 20, 1981 to December 31, 1982, the nominees were: Drs. Felino V. Barnes, Cleveland; Ronald B. Berggren, Columbus; Thomas E. Fox, Mason; Roland A. Gandy, Jr., Toledo; Edward G. Kilroy, Cleveland; James E. Matson, Columbus; and Carl E. Spragg, New Concord. The nominations were duly seconded and there were no further nominations from the floor. A

written ballot was taken and Drs. Gandy and Kilroy were declared elected.

COMMITTEE ON PRESIDENT'S ADDRESS

Dr. Thomas then called for the report of the Reference Committee on President's Address, which was presented by Dr. James W. Wiggin, Richland County, Chairman of the Committee. The report read as follows:

Dr. Thomas has reported to us on a good year for the Ohio State Medical Association — one relatively free from "major crises" and "divisive issues."

He reviewed some of the good things which have been accomplished during his term of office. The Stabilization Reserve Fund has returned 25 million dollars to the physicians of Ohio. OSMA has acquired additional valuable property adjacent to its headquarters. Our Legislative Department has continued its highly effective work both in Columbus and in Washington, and an ombudsman program has been created which is assisting physicians in dealing with third-party payers.

Dr. Thomas underscored Dr. Bates' report on the great success of our Physicians Insurance Company of Ohio. He also called to our attention the good work of the Communications Department, and especially of Dr. Roger Blackwell, in looking into a new area of concern — competition in the health care field.

Dr. Thomas then elaborated on an area of special accomplishment — the bringing into our organization of 4,000 new members. He recognized the assistance of the Membership Committee and its chairman, Dr. Tom Morgan, in accomplishing this feat. These new members came from among practicing physicians and house staff, as well as the vast majority of students in Ohio's six medical schools. PICO was also recognized for its interest and for its important financial investment in this program. Some of these young men and women "will be brought into the framework of organized medicine as much as eight or nine years earlier than they probably . . . would have been" with opportunities to participate at county, state, and national levels. Dr. Thomas expressed his hope that programs specifically for students would be established at each of these levels, and that students and house staff would not be treated as second-class members. He asked this House to use wisdom in deliberating the resolutions relating to this subject.

The Committee would like to underscore Dr. Thomas' recognition of our very fine OSMA staff, and especially of Hart Page, whose dedication and loyalty have served as such a fine example for all of us, membership and staff alike.

Finally, while recognizing the long tradition of and the original reasons for the Committee on the President's Address, we would like to suggest that OSMA Council review the need for such a separate committee and consider the possibility of assigning the President's Address to one ot the regular reference committees in the future.

By official action, *the House voted that the report be filed.*

REPORT OF RESOLUTIONS COMMITTEE NO. 1

Dr. Paul S. Metzger, Franklin County, reported for Resolutions Committee No. 1, of which he was Chairman. The report is as follows:

Mr. President and members of the House of Delegates. Resolutions Committee No. 1 met in open session on Monday, May 18, 1981 and heard testimony on Resolutions 1-81 through 19-81 and Emergency Resolutions 58-81 and 59-81.

RESOLUTION 1-81

To Amend the OSMA Constitution and Bylaws to Create a Medical Student Business Section and to Provide for the Selection of Representatives of the Medical Student Business Section to the House of Delegates

RESOLUTION 2-81

Voting Membership for Medical Students

The Committee considered these resolutions together. The Committee proposes a substitute resolution in lieu of Resolutions 1-81 and 2-81 as follows:

It was the decision of the House that Substitute Resolution No. 1-81, should be separated in four parts: "I. 1.," "I. 2.," "I. 3.," and "II." Each section would be voted on individually, as follows:

SUBSTITUTE RESOLUTION 1-81

To Amend the OSMA Constitution and Bylaws to Create a Medical Student Section and to Provide for the Selection of Representatives of the Medical Student Section to the House of Delegates

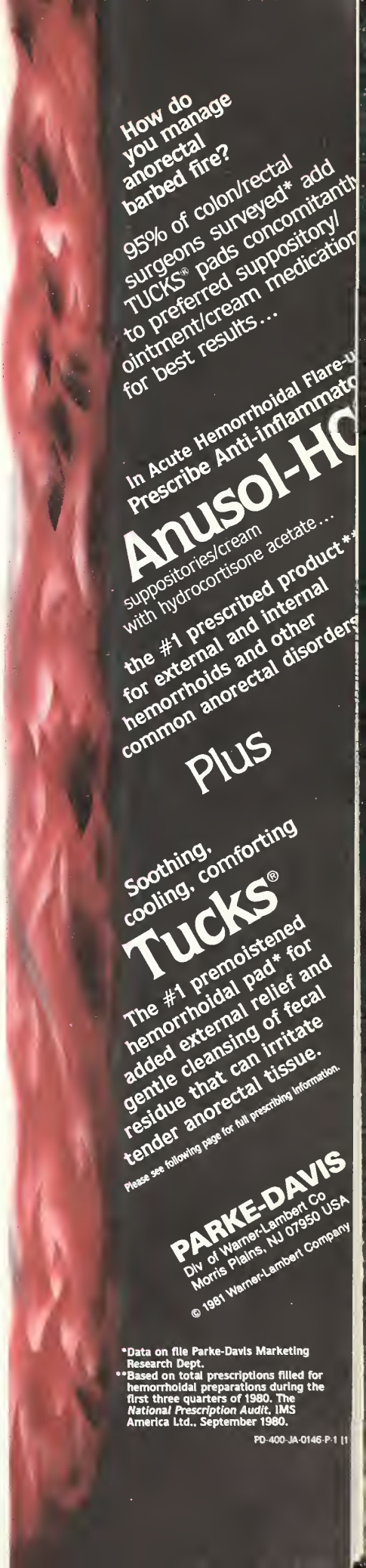
I. WHEREAS, Medical students represent the future members of our profession; and

WHEREAS, It is important to encourage future physicians to participate in the activities of organized medicine at every level; and

WHEREAS, OSMA Council believes that revision of the OSMA Constitution and Bylaws to create a medical student section is appropriate, it recommends for adoption by the House of Delegates the following:

1. RESOLVED, That the OSMA Constitution, Article VII, ("The Council"), shall be amended to provide as follows:

> The Council shall consist of one councilor from each councilor district, one NON-VOTING student member from the medical student section and the other elected officers of this Association. The Council shall be the executive



TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads
Hemorrhoids and other anorectal uses–TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witchhazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.
Vaginal Uses–Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
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body of this Association and it shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates.

By official action, *the House voted to amend and to adopt "I. 1." of Substitute Resolution 1-81. The amendment is indicated in capital letters.*

2. RESOLVED, That the OSMA Bylaws, Chapter 1, ("Membership") Section 2 ("Classification of Membership"), Subsection (i) ("Student Members") shall be amended to provide as follows:

Student Members of this Association shall comprise those students in good standing who are pursuing the diploma of Doctor of Medicine or Doctor of Osteopathy in an approved medical or osteopathic college or institution in the State of Ohio and are approved for student membership by the Council. Student members shall comprise the medical group known as the medical student section. Said section shall be governed by and operate under separate bylaws approved by the council. EXCEPT AS OTHERWISE PROVIDED IN ARTICLE 7 OF THE CONSTITUTION, student members in good standing of this association shall have the right to vote and hold office IN THIS ASSOCIATION.

By official action, *the House voted to adopt "I. 2." of Substitute Resolution 1-81, with editorial changes, denoted in capital letters.*

3. RESOLVED, That OSMA Bylaws Chapter 7, ("The Council") Section 4, ("Individual Duties of Councilors") shall be amended to provide as follows:

Each Councilor shall be the organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purposes of inquiring into the condition of the profession and of each component society in his district and of keeping in touch with the activities of each of such societies. In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics.

The duties of the NON-VOTING councilor from the medical student section shall be set forth in the bylaws of said section."

By official action, *the House voted to amend and to adopt "I. 3." of Substitute Resolution 1-81. The amendment is indicated in capital letters.*

II. WHEREAS, The Constitution and Bylaws of the OSMA have been amended to create a Medical Student Section; THEREFORE BE IT

RESOLVED, That pursuant to the OSMA Constitution, Article IV, ("House of Delegates") Subsection (3), the Medical Student Section shall have six representatives to the House of Delegates commencing with the Annual Meeting in 1982, said delegates to be selected in accordance with the Bylaws of the Medical Student Section to be approved by Council; BE IT FURTHER

RESOLVED, That for purposes of representation in the House of Delegates, student members shall not be counted at the individual district level, but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the student members of each medical school elect their own delegate, and, Mr. President, I so move.

By official action, *the House voted to adopt "II." of Substitute Resolution No. 1-81.*

RESOLUTION 3-81

Organizational Structure of the OSMA

The Committee heard testimony regarding this resolution and recommends an amended resolution as follows:

AMENDED RESOLUTION 3-81

Organizational Structure of the OSMA

WHEREAS, The present organizational structure of the OSMA has not changed substantially for many years; and

WHEREAS, The logistic ability of staff, officers and the committee structure to respond to the varying needs of rural, urban, regional, state and national constituencies is hampered by the present structure; THEREFORE BE IT

RESOLVED, That the President of the Ohio State Medical Association appoint a task force OF ONE MEMBER FROM EACH DISTRICT to study the appropriateness of the organizational structure of the OSMA and component county medical societies in today's complex society. The task force will report its findings and recommendations, if any, for changes in organizational structure, including the possibility of specialty society representation, to the House of Delegates in May, 1982 and, Mr. President, I so move.

By official action, *the House voted to amend and to adopt Amended Resolution 3-81. The amendment is indicated in capital letters.*

RESOLUTION 4-81

Specialty Society Representation

RESOLUTION 5-81

Specialty Society Representation in OSMA

The Committee reviewed extensive testimony presented on these resolutions and there was, in general, favorable reaction to specialty society representation. However, it was the consensus of the Committee, that this be delayed until the Task Force study as described in Amended Resolution 3-81 is completed and reported back to this House of Delegates. In the meantime the Council is urged to improve communications between the OSMA and each identified specialty society.

The Committee recommends that Resolutions 4-81 and 5-81 be postponed definitely until the 1982 Annual Meeting and, Mr. President, I so move.

By official action, *the House voted to adopt the Committee's recommendation that Resolutions 4-81 and 5-81 be postponed definitely until the 1982 Annual Meeting.*

RESOLUTION 6-81

Physician for Office of OSMA Executive Vice President

There was little support for this resolution in open testimony, and there were no compelling reasons to accept this organizational modification calling for a physician Executive Vice President. The current staff arrangement has served the Association in a superior fashion. Therefore, Mr. President, the Committee recommends that Resolution 6-81 be *not* adopted and, I so move.

By official action, *the House voted to reject Resolution No. 6-81.*

RESOLUTION 7-81

Election of Officers

The Committee reviewed the testimony and discussed this resolution at length. It was the unanimous opinion of the Committee that the present system of electing delegates provides the optimum "evaluative" system for selecting the most capable leadership and therefore it is recommended that Resolution 7-81 be *not* adopted and, Mr. President, I so move.

By official action, *the House voted to reject Resolution No. 7-81.*

RESOLUTION 8-81

Direct Election of District Councilors

The Committee heard conflicting testimony on this resolution but was persuaded by the problem of the fiduciary power granted to an interim governing body (the Council) by its parent governing body (the House of Delegates). It was the opinion of OSMA legal counsel that the House of Delegates should elect the members of the fiduciary body in order to make it an appropriate interim governing board. The Committee therefore recommends that Resolution 8-81 be *not* adopted and, Mr. President, I so move.

By official action, *the House voted to reject Resolution No. 8-81.*

RESOLUTION 10-81

Reduction of Dues at Age 70

The Committee heard testimony and discussed the pros and cons of this resolution. Adoption of the resolution would cost the OSMA an estimated $46,000 - $50,000 in lost income per year. At the present time retired/disabled members may request waiver of dues. It is our understanding that the Membership Committee is investigating the possibility of a phased system of reduced dues for members over 70 years of age.

For these reasons the Committee recommends Resolution 10-81 be *not* adopted and, Mr. President, I so move.

By official action, *the House voted to reject Resolution No. 10-81.*

RESOLUTION 11-81

Resolution Screening Committee

Although the Committee was in sympathy with the intent of this resolution, it was concerned that such a mechanism for screening resolutions might infringe on an individual's right to propose and submit resolutions. Therefore, Mr. President, the Committee recommends that Resolution 11-81 be *not* adopted and, I so move.

By official action, *the House voted to reject Resolution No. 11-81.*

RESOLUTION 12-81

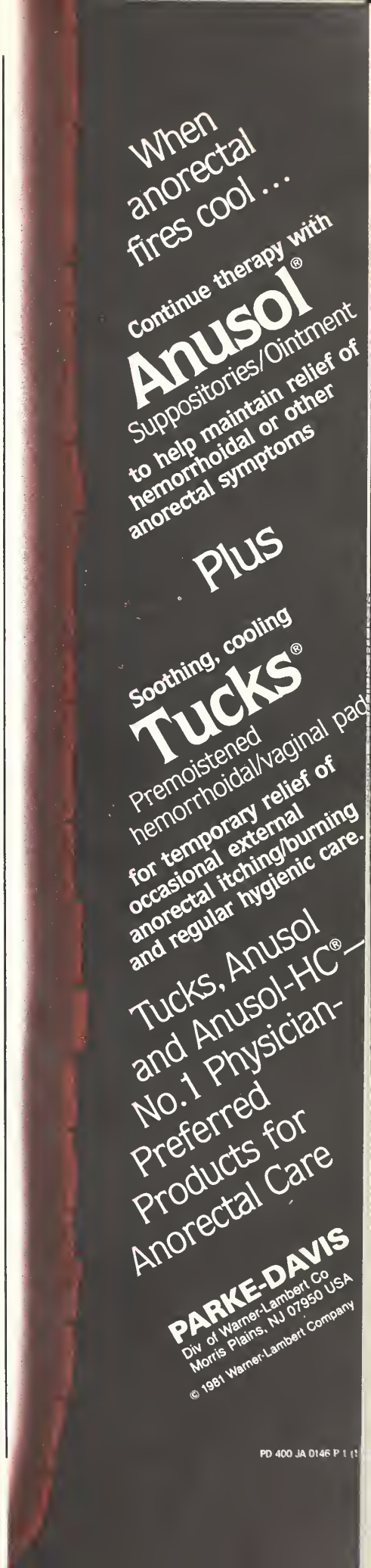
Ohio State Medical Association Annual Meeting

It was evident from the testimony presented at the open hearing that there is considerable sentiment for holding the Annual Meeting during a shorter time period. Because of the complexity of this issue, the Committee did not feel it could recommend specific days and times for a format change. The Committee recommends referral of Resolution 12-81 and all matters concerning format of the Annual Meeting be referred to the Council for study and action and, Mr. President, I so move.

By official action, *the House voted to amend Resolution 12-81 and to adopt it.* The resolution reads as follows, with the amendments indicated in capital letters and the deletions as noted:

WHEREAS, There is a need to stimulate attendance at annual OSMA meetings by nondelegate members, reduce inconvenience for delegate members, and to encourage scientific and technical exhibitions; therefore be it

RESOLVED, That the ~~Ohio State Medical Association meetings in the future be scheduled as follows~~: ANNUAL MEETING OF THE HOUSE OF DELEGATES OF THE OHIO STATE MEDICAL ASSOCIATION BE



SCHEDULED AS SOON AS PRACTICAL, AS FOLLOWS: ~~Scientific exhibits, technical exhibits, scientific and social sessions to commence on Thursday evenings. Opening session of the House of Delegates to commence on Friday mornings at 9 a.m. Resolution Reference Committee meetings to commence on Friday afternoons at 1 p.m. The closing meeting of the House of Delegates to commence on Sundays at 9 a.m.~~

THE OPENING SESSION OF THE HOUSE OF DELEGATES WILL BEGIN ON THURSDAY A.M. AND THE CLOSING SESSION OF THE HOUSE OF DELEGATES WILL BEGIN BY NOON ON SATURDAY.

RESOLUTION 13-81

Needed Physician Support for Neonatal Nurses

The Committee reviewed the testimony of the author of this resolution along with the open hearing testimony and concluded that physician directed protocols adequately protected the neonatal nurses and therefore, the Committee recommends that Resolution 13-81 be *not* adopted and, Mr. President, I so move.

By official action, *the House voted to reject Resolution 13-81.*

RESOLUTION 14-81

The Ohio State Medical Journal

This resolution urges change in the format and content of *The Ohio State Medical Journal* because of lack of emphasis on scientific material. An in-depth survey of *Journal* readers completed in 1979 showed only minimal demand for inclusion of this type information. The format was therefore changed to conform to the measured interests of the *Journal's* readers. This change has been widely accepted resulting in increased advertising revenues. The Committee therefore recommends that Resolution 14-81 be *not* adopted and, Mr. President, I so move.

By official action, *the House voted to reject Resolution No. 14-81.*

RESOLUTION 15-81

Women in Medicine

The Committee considered the testimony and was entirely sympathetic with studying women physician involvement in organized medicine. However, the Committee saw little merit in establishing a special committee to implement this concept. Therefore, the Committee recommends a substitute resolution as follows:

SUBSTITUTE RESOLUTION 15-81

Women in Medicine

BE IT RESOLVED, that the problems and concerns of women members be referred to the Committee on Membership through the Council for study and action. Mr. President, I so move.

By official action, *the House voted to adopt Substitute Resolution No. 15-81.*

RESOLUTION 16-81

Comprehensive Placement Service

The Committee in reviewing the testimony on this resolution noted that there could be an expenditure of up to $50,000.00 to upgrade the physicians placement activity of the association. The Committee felt that this matter deserves a more thorough investigation than the Committee was capable of providing with the information available. The Committee therefore recommends that Resolution 16-81 be referred to the Council for study and action and, Mr. President, I so move.

By official action, *the House voted to adopt the Committee's recommendation that Resolution 16-81 be referred to the Council for study and action.*

RESOLUTION 17-81

Huron County Medical Society Requests OSMA Medical Legal Fund Assistance

The Committee received a substantial amount of testimony relative to this resolution. This resolution requests OSMA financial assistance in prosecuting a lawsuit by a member. The OSMA Legal Defense Fund was created to aid in defense of suits under criteria adopted by Council. This suit does not qualify for such aid under those criteria.

In addition, it is the opinion of the OSMA legal counsel that this suit, in all probability, cannot be carried to a successful conclusion.

For these reasons, the Committee recommends that Resolution 17-81 be *not* adopted and, Mr. President, I so move.

By official action, *the House voted to reject Resolution No. 17-81.*

RESOLUTION 18-81

Legal Defense Fund Assistance to Northwest Ohio Small Hospitals (Law Firm of Eckler & Bricker-Columbus, Ohio)

This resolution calls for financial support from the OSMA Legal Defense Fund for a suit being pursued by a number of hospitals in Northwest Ohio. It is the opinion of the Committee that this particular suit does not qualify for legal *defense* fund financial assistance. The Committee therefore recommends that Resolution 18-81 be *not* adopted and, Mr. President, I so move.

By official action, *the House voted to reject Resolution No. 18-81.*

RESOLUTION 19-81

Federal Regionalism

The Committee considered the testimony of the author of this resolution and was sympathetic to the concerns of "federal regionalism." However, the Committee was made aware of grassroots lobbying regulations and the potential risks associated thereto in regard to the tax exempt status of the OSMA.

The Committee therefore recommends a substitute resolution as follows:

SUBSTITUTE RESOLUTION 19-81

Federal Regionalism

BE IT RESOLVED, That the OSMA publications carry appropriate and timely announcement of the dates of public hearings on S.B. 101. (Declares the Presidential Executive order establishing regionalism void.) Mr. President, I move the adoption of Substitute Resolution 19-81.

By official action, *the House voted to adopt Substitute Resolution No. 19-81.*

RESOLUTION 58-81

Direct Membership in AMA

The Committee considered the testimony regarding this resolution and proposes the following substitute resolution to guide the Ohio Delegation to the AMA in considering the issue of direct membership in the AMA:

SUBSTITUTE RESOLUTION 58-81

Direct Membership in AMA

BE IT RESOLVED, That the House of Delegates of the OSMA instruct the Ohio Delegation to the AMA to oppose any action by the AMA which would lead to or allow direct AMA membership in Ohio.

Mr. President, I move the adoption of Substitute Resolution 58-81.

By official action, *the House voted to amend Substitute Resolution 58-81, and to adopt it. The Resolution reads as follows:*

AMENDED SUBSTITUTE RESOLUTION 58-81

Direct Membership in AMA

WHEREAS, A report recommending a Bylaws change to permit direct membership in the AMA is being recommended by the AMA Board of Trustees to the House of Delegates of the AMA; and

WHEREAS, This is a marketing strategy which would weaken or destroy the Federation concept of organized medicine; therefore be it

RESOLVED, THAT THE OSMA HOUSE OF DELEGATES ADVISES ITS AMA DELEGATION TO SUPPORT THE FEDERATION CONCEPT FOR AMA, STATE AND COUNTY MEMBERSHIP; AND BE IT FURTHER

RESOLVED, THAT DIRECT AMA MEMBERSHIP BE PERMITTED ONLY WHERE COUNTY AND/OR STATE MEMBERSHIP IS NOT AVAILABLE, AND THAT THE AMA MUST CONSULT WITH THE CONSTITUENT STATE SOCIETIES ON DIRECT MEMBERS TO CONFIRM THEIR VALIDITY; AND BE IT FURTHER

RESOLVED, THAT THIS RESOLUTION BE TRANSMITTED TO THE AMA HOUSE OF DELEGATES FOR CONSIDERATION AT THE JUNE, 1981 MEETING.

RESOLUTION 59-81

Restructure of AMA

The Committee in considering this resolution felt there was some misunderstanding concerning the AMA's intention in proposing to eliminate the Committee on Continuing Physician Education. It is the Committee's understanding that the AMA does not intend to withdraw from its activities in

educational accreditation. Therefore, the Committee recommends that Resolution 59-81 be *not* adopted and, Mr. President, I so move.

By official action, *the House voted to reject Resolution No. 59-81.*

RESOLUTION 9-81

Privilege of Floor of Past Councilors

The Committee placed Resolution 9-81 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, Past Presidents of the Ohio State Medical Association are afforded the privilege of the House of Delegates at the Annual Meeting of the Ohio State Medical Association; and

WHEREAS, Many past councilors have considerable experience and special knowledge or insight that could be valuable to the House in its deliberations; therefore be it

RESOLVED, That the privilege of the floor of the House of Delegates be extended to all past councilors of the Ohio State Medical Association.

By consent, *the House adopted Resolution 9-81.*

THE REPORT OF RESOLUTIONS COMMITTEE NO 1, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

REPORT OF RESOLUTIONS COMMITTEE NO. 2

Dr. Joseph Sudimack, Jr., Trumbull County, reported for Resolutions Committee No. 2, of which he was Chairman. The report is as follows:

Resolutions Committee No. 2 met in open session at 7:30 a.m. on Monday, May 18, 1981, with all members present. Testimony and discussion was heard on Resolutions No. 20-81 through 33-81, as well as Resolution No. 60-81 and Report C.

The Committee would like to thank those who participated in the deliberations and thereby demonstrated sincere "Involvement" in their profession.

RESOLUTION 21-81

IMMEDIATE IMPLEMENTATION OF 1979 APPROVED REPORT G OF THE AMA HOUSE OF DELEGATES

The Committee felt Resolution 21-81 addressed a subject that has been properly dealt with by Resolution 19-80. Therefore, Mr. President, the Committee recommends that Resolution 21-81 be *not* adopted and I so move.

By official action, *the House voted to reject Resolution No. 21-81.*

RESOLUTION 23-81

Reconvene Task Force on Professional Liability

It was the opinion of the Committee that the Task Force on Professional Liability is adequately dealing with the issues raised in Resolution 23-81. However, the Committee did feel that it would be appropriate for an occasional or intermittent report to the House of Delegates regarding its activities. Therefore, Mr. President, the Committee recommends that Resolution 23-81 be *not* adopted and I so move.

By official action, *the House voted to amend the original resolution, as indicated by capital letters, and to adopt it.* The resolution, as amended, reads as follows:

WHEREAS, Travelers Insurance Company recently reached an out-of-court settlement with 5500 physicians in Southern California for approximately $50 million in reimbursements of payments made for medical malpractice insurance; and

WHEREAS, The then Ohio State Commissioner of Insurance negotiated with the OSMA Task Force on Professional Liability to make underwriters ultimately accountable for gross disparities between premiums and judgments, settlements and legal fees; and

WHEREAS, The "medical malpractice crisis" of the mid 1970s has produced four years of actuarial data with which to make such determinations; therefore be it

RESOLVED, The OSMA Council reconvene its Task Force on Professional Liability to enter into dialogue with the State Insurance Commissioner's office in search of the promised but not yet forthcoming accountability figures; and be it further

RESOLVED, The OSMA Council collate and disseminate this information to all Ohio physicians together with its recommendations; AND BE IT FURTHER

RESOLVED, THAT THE OSMA TASK FORCE ON PROFESSIONAL LIABILITY ISSUE PERIODIC REPORTS OF ITS ACTIVITIES AT LEAST EVERY THREE MONTHS THROUGH ITS PUBLICATIONS OR BY SPECIAL COMMUNICATION.

RESOLUTION 24-81

Malpractice Insurance Rates

The solution of the problems addressed in Resolution 24-81 must be obtained on an individual basis to insure accuracy and is available from the Ohio State Medical Association headquarters and therefore, Mr. President, the Committee recommends that Resolution 24-81 be *not* adopted and I so move.

By official action, *the House voted to reject Resolution No. 24-81.*

RESOLUTION 25-81

Membership Dues Refund

The OSMA Committee on Membership has studied the concept that was addressed in Resolution 25-81 and has concluded that such a Membership Dues Refund program is not applicable to OSMA. Therefore, Mr. President, the Committee recommends that Resolution 25-81 be *not* adopted and I so move.

By official action, *the House voted to reject Resolution No. 25-81.*

RESOLUTION 26-81

Assignment of Health Insurance Benefits

Although the Committee appreciates the problem outlined in Resolution 26-81, the Committee feels that the RESOLVES are not a practical solution to the problem presented and therefore, Mr. President, the Committee recommends that Resolution 26-81 be *not* adopted and I so move.

By official action, *the House voted to reject Resolution No. 26-81.*

RESOLUTION 27-81

Prompt Payment of Insurance Claims

The Committee was strongly opposed to legislative or regulatory remedies regarding payment of insurance claims. Therefore, Mr. President, the Committee recommends that Resolution 27-81 be *not* adopted and I so move.

By official action, *the House voted to reject Resolution No. 27-81.*

RESOLUTION 28-81

Interest Payments on Overdue Accounts

The Committee felt that Resolution 28-81 would result in additional regulatory complications for physicians and is demeaning to a learned profession. Therefore, Mr. President, the Committee recommends that Resolution 28-81 be *not* adopted and I so move.

By official action, *the House voted to reject Resolution No. 28-81.*

RESOLUTION 29-81

The Right of a Hospitalized Patient to Choose His Attending or Consulting Physician

After a discussion of Resolution No. 29-81, the Committee voted to recommend the following amended resolution:

RESOLUTION 29-81

The Right of a Hospitalized Patient to Choose His Attending or Consulting Physician

After a discussion of Resolution No. 29-81, the Committee voted to recommend the following amended resolution:

AMENDED RESOLUTION 29-81

The Right of a Hospitalized Patient to Choose His Attending or Consulting Physician

WHEREAS, Some contractural arrangements between the hospital governing body and certain physicians providing attending or consultant physician services to the exclusion of other physicians on the medical staff having similar privileges, appear to conflict with the basic right of the patient to freely choose his/her physicians; therefore be it

RESOLVED, By the Ohio State Medical Association that nothing should preclude the right of a hospitalized patient to choose his/her attending or consulting physician provided that the physician has privileges to practice and is qualified to perform required services in the hospital and is willing to accept the patient; and be it further

RESOLVED, That this resolution be presented to the AMA for submission

to the Joint Commission on Accreditation of Hospitals for consideration.

By official action, *the House voted to adopt Amended Resolution No. 29-81.*

RESOLUTION 30-81

Amendment Process of Medical Staff Bylaws

The Committee felt that the matter of unilateral decision by Boards of Trustees had been adequately dealt with by Resolution 44-78, Rights of Lay Boards of Trustees to Mandate Policy to Medical Staffs. Resolution 44-78 is current OSMA policy. Therefore, Mr. President, the Committee recommends that Resolution 30-81 be *not* adopted and I so move.

By official action, *the House voted to refer Resolution No. 30-81 to the OSMA Council for study and action.*

RESOLUTION 32-81

Ohio Medical Hall of Fame

The Committee felt that the present method of recognizing outstanding Ohio physicians with the Ohio State Medical Association's Distinguished Service Citation is adequate and appropriate. Further, the Committee felt that establishment of a Hall of Fame would be cost prohibitive. Therefore, Mr. President, the Committee recommends that Resolution 32-81 be *not* adopted and I so move.

By official action, *the House voted to reject Resolution No. 32-81.*

RESOLUTION 33-81

Freedom of Choice in Medical Care

The Committee re-enforced the traditional concept of treating patients regardless of their ability or method of payment. Therefore, Mr. President, the Committee recommends that Resolution 33-81 be *not* adopted and I so move.

By official action, *the House voted to reject Resolution No. 33-81.*

RESOLUTION 60-81

Hospital Malpractice Insurance

The weight of the testimony and the feelings of the Committee were strongly in favor of Resolution 60-81 and therefore, Mr. President, the Committee recommends adoption of Resolution 60-81 and I so move.

By official action, *the House voted to adopt Resolution No. 60-81.* The resolution reads as follows:

WHEREAS, Some insurance companies providing professional liability insurance for hospitals include a clause which permits the insurance company to sue a physician in the name of a hospital, if the insurance company believes the action is warranted; and

WHEREAS, The contract does not give the hospital the right to refuse to participate in such an action; and

WHEREAS, Three suits have been brought against Cleveland physicians by such insurers in the name of the hospitals over the strong objections of the hospitals; and

WHEREAS, Actions such as these will seriously impair the relationships between medical staffs and hospitals; therefore be it

RESOLVED, That hospitals be encouraged to insist that contracts for hospital professional liability insurance require that the carrier obtain the consent of the policyholder prior to initiating legal action against a physician in the name of the hospital; and be it further

RESOLVED, That this resolution be introduced into the AMA House of Delegates Meeting by the Ohio Delegation to the AMA in time for the June, 1981, AMA Annual Meeting.

REPORT C

Categorization of Hospital Facilities for Emergency Medical Services in Ohio

The Committee heard testimony and reviewed Report C, Categorization of Hospital Facilities for Emergency Medical Services in Ohio, and recommends that it be filed, and Mr. President, I so move.

By official action, *the House voted to adopt the Committee's recommendation that Report C be filed.*

RESOLUTION 20-81

Special Commendation to the OSMA and California Delegations to the AMA

The Committee placed Resolution 20-81 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, The OSMA and California delegations to the AMA demonstrated outstanding leadership at the recent AMA meeting; and

WHEREAS, Actions of this type demonstrate to the rank and file the value of membership in organized medicine; therefore be it

RESOLVED, That the House of Delegates of the OSMA express special commendation to the OSMA and CMA delegations to the AMA for the outstanding leadership they demonstrated during the 1980 Interim session of the AMA.

By consent, *the House adopted Resolution 20-81, with editorial changes.*

RESOLUTION 22-81

Continued Support by OSMA and County Societies of the AAMA-OSS

The Committee placed Resolution No. 22-81 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, The American Association of Medical Assistants — Ohio State Society is an outstanding organization dedicated to the continuing education and self-improvement of medical assistants; and

WHEREAS, We recognize the professional loyalty and allegiance given to physician employers by its members which have made for a common endeavor to provide quality medical services; and

WHEREAS, The AAMA-OSS has served as an ally of physicians at all levels of organization; therefore be it

RESOLVED, That OSMA commends the AAMA-OSS and its chapters for their professionalism in continuing education and their devotion to physicians; and be it further

RESOLVED, That the OSMA and the county medical societies continue active, formal support of the AAMA-OSS and its chapters for continued professionalism.

By consent, *the House adopted Resolution No. 22-81.*

RESOLUTION 31-81

Organized Medicine Participation with Business Leaders

The Committee placed Resolution No. 31-81 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, There is a renewed need for



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MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

physician input in the development of health benefits and the cost of delivering medical services in our communities; therefore be it

RESOLVED, That the OSMA and its component county societies give emphasis to the development of good professional relations with business and community leaders; and be it further

RESOLVED, That the OSMA and its component county medical society advisory participation be given equally to all business entities.

By consent, *the House adopted Resolution No. 31-81.*

THE REPORT OF RESOLUTIONS COMMITTEE NO. 2, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

REPORT OF RESOLUTIONS COMMITTEE NO. 3

Dr. Robert M. Zollinger, Jr., Cuyahoga County, reported for Resolutions Committee No. 3, of which he was Chairman. The report is as follows:

Mr. President and members of the House of Delegates. Resolutions Committee No. 3 met in open session on Monday, May 18, 1981 and heard testimony relating to Resolutions 34-81 through 57-81 and Resolution 61-81.

RESOLUTION 34-81 — Repeal P.S.R.O.
RESOLUTION 35-81 — Repeal P.S.R.O.
RESOLUTION 38-81 — Peer Review Organizations

The Committee considered these resolutions together and offers the following amended resolution to substitute for all three as the intent of these resolutions was similar:

SUBSTITUTE RESOLUTION 34-81

P.S.R.O.

WHEREAS, The P.S.R.O. Legislation (92-603) was introduced and enacted primarily as a "cost controls" mechanism; and

WHEREAS, The American Medical Association at its December, 1980 interim meeting, voted an official position for the first time to repeal P.S.R.O., THEREFORE BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association reaffirm the "Ohio Amendment" — *that the current AMA policy shall be to continue professionally directed efforts to ensure that care provided to patients is of high quality and appropriate duration, and is rendered in an appropriate setting at a reasonable cost and to encourage the elimination of all government directed peer review programs, including P.S.R.O.* Accordingly, Resolution Committee No. 3 recommends that Substitute Resolution No. 34-81 be adopted, and Mr. President, I so move.

By official action, *the House voted to adopt Substitute Resolution No. 34-81.*

RESOLUTION 36-81

Congratulations OSMA/California Delegations

With permission of the House, Resolution 36-81 was omitted from consideration, because it is a duplication of previously adopted Resolution 20-81.

RESOLUTION 37-81

Immunity to Civil Liability for Communications to Peer Review Committees

Inasmuch as Ohio House Bill 51 was enacted by the Ohio General Assembly after submission of this resolution, Resolutions Committee No. 3 recommends that Resolution No. 37-81 be *not adopted.* It embraces an important concept but it is no longer necessary. Mr. President, I so move.

By official action, *the House voted to reject Resolution 37-81.*

RESOLUTION 39-81

Continuing Medical Education

RESOLUTION 40-81

Continuing Medical Education

RESOLUTION 41-81

Abolition of Continuing Medical Education for Relicensure

The Committee reviewed Resolution 7-80 which is still in force and which covers the same subject in similar manner. Resolution 7-80 reads as follows:

"RESOLVED, That the OSMA is opposed to compulsory continuing medical education as a requirement for reregistration of certificate and will attempt to initiate legislation at an appropriate time to abolish this requirement."

Testimony was presented that it would be politically and publicly difficult to seek outright repeal at this time. However, it was

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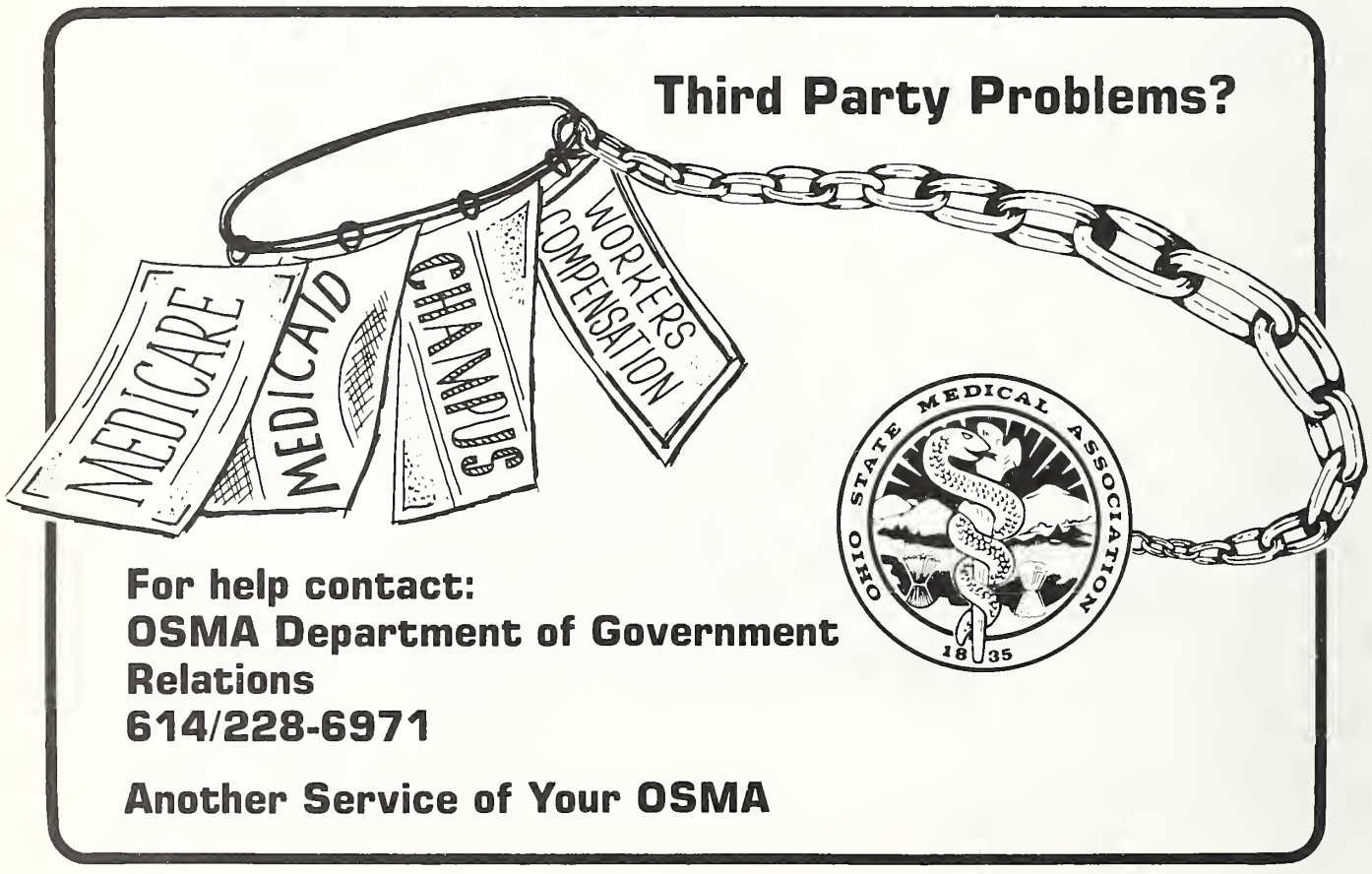
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noted that the OSMA Legislative Department is working for repeal by amendment and to date has entered legislative amendments simplifying CME recordkeeping for relicensure of Ohio physicians.

Accordingly, Resolutions Committee No. 3 recommends that Resolution 39-81, Resolution 40-81, Resolution 41-81 be *not* adopted as they are not necessary because of Resolution 7-80. Mr. President, I so move.

It was the decision of the House, that Resolutions 39-81, 40-81 and 41-81 be considered separately.

By official action of the House, *all three resolutions were rejected.*

RESOLUTION 42-81

Opposition to Present Attempts to Change the Requirements for a Medical Certificate to Practice Medicine in Ohio

Extensive testimony was presented to the Committee, including a potential compromise which would have allowed the State Medical Board to determine which examination is required and to determine an appropriate passing grade in each subject area. Those who offered testimony and the Committee members determined that the key issue was whether or not a special class of limited licensure in an academic setting should be created. Although there was merit in the proposed compromise which brought both sides together, the unanimous opinion of Resolutions Committee No. 3 was to oppose this solution. It would change state law for the benefit of a few at present and it might allow abuses in the future. Accordingly, Resolutions Committee No. 3 offers Amended Resolution No. 42-81 as follows:

AMENDED RESOLUTION 42-81

Opposition to Present Attempts to Change the Requirements for a Medical Certificate to Practice Medicine in Ohio

WHEREAS, There has been no demonstrated public need to decrease or otherwise dilute requirements for medical licensure; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association oppose a special class of "teaching and/or visiting" certificate and affirm that any physician who actively treats patients should continue to meet all present licensure requirements. Mr. President, I move for *adoption* of Amended Resolution No. 42-81.

By official action, *the House voted to adopt Amended Resolution 42-81.*

RESOLUTION 43-81

Change in the Ohio Medical Licensure Law

The Committee found that this resolution was too broad and nonspecific in its RESOLVED. We noted also that the OSMA Task Force on Medical Licensure and Enforcement and the Committee on State Legislation have made recommendations which specifically address each of the issues raised in this resolution. Accordingly, Resolutions Committee No. 3 recommends that Resolution No. 43-81 be *not adopted*. Mr. President, I so move.

By official action, *the House voted to reject Resolution 43-81.*

RESOLUTION 44-81

Appropriateness Review of Emergency Rooms

The committee noted that emergency departments have already been withdrawn from appropriateness review. Accordingly, Resolutions Committee No. 3 recommends that Resolution 44-81 be *not adopted* inasmuch as the intent of this resolution has already been accomplished. Mr. President, I so move.

By official action, *the House voted to reject Resolution 44-81.*

RESOLUTION 45-81

Welfare Payment Inequities

The Committee heard strong support for this resolution from many physicians who presented specific examples of financial hardship created by current Medicaid policies. These involved their procedures for validation, complex processing of claims with confusing regulations, and delayed payments. Accordingly, Resolutions Committee No. 3 offers the following amended resolution:

AMENDED RESOLUTION 45-81

Welfare Payment Inequities

WHEREAS, An inequity exists between the partial payment of welfare claims to doctors and the full payment of claims to others providing goods and/or services to welfare recipients in the State of Ohio; and

WHEREAS, the Welfare Department pays far less than 100% to doctors for services rendered to welfare patients in the state of Ohio and has not updated its fee schedule to reflect inflation; and

WHEREAS, This discrimination especially reflects on physicians in the deprived areas, whose practices consist largely of welfare recipients and who, at great sacrifice, take care of indigents;

THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association make every effort to urge the Welfare Department of the State of Ohio to revise its practice of partial payment of a doctor's fee and to adopt a policy of paying doctors in full for services rendered a welfare recipient and that it be further urged to request a reduction in the length of time it takes to pay a doctor; AND BE IT FURTHER

RESOLVED, That the OSMA Committee on Government Medical Care Programs investigate and attempt to improve the validation, information exchange, and reimbursement systems of the Welfare Department.

Accordingly, Resolutions Committee No. 3 recommends that Amended Resolution 45-81 be *adopted* and, Mr. President, I so move.

By official action, *the House voted to adopt Amended Resolution 45-81.*

RESOLUTION 46-81

Statewide Prevailing Area for Third-Party Reimbursement in Ohio

Physicians offered equal testimony both for and against this resolution. By a split vote of 9-3, the Committee felt that this subject was one of an actuarial nature and therefore was not appropriate business for consideration by the House of Delegates. The three minority vote members were sympathetic to the concept of this resolution. However, they did not wish to prepare a formal minority report. Accordingly, Resolution Committee No. 3 recommends that Resolution 46-81 be *not* adopted and, Mr. President I so move.

By official action, *the House voted to reject Resolution 46-81.*

RESOLUTION 47-81

Manpower

Spirited testimony was received as to the validity of GMENAC projections of physician manpower. It was noted that Resolution No. 14-79 addressed physician manpower needs in Ohio and resulted in the Committee on Health Manpower study. Unfortunately the Committee's investigation has spanned two years and has not resulted in sufficient informational output. The current resolution expands the scope of Resolution 14-79 to assess both the roles of physicians and nonphysician health care providers in the overall delivery of medical services. Accordingly, Resolutions Committee No. 3 offers Amended Resolution 47-81 as follows:

AMENDED RESOLUTION 47-81

Manpower

WHEREAS, The GMENAC reports have stated that we will soon have a marked oversupply of both physicians and nonphysician health care providers; and

WHEREAS, All types of nonphysicians have sought to increase their sphere of professional activity through legislative action; THEREFORE BE IT

RESOLVED, That the OSMA continue and accelerate manpower studies of both physicians and nonphysician health care providers in Ohio.

Accordingly, Resolutions Committee No. 3 recommends that Amended Resolution 47-81 be *adopted*, and Mr. President, I so move.

By official action, *the House voted to adopt Amended Resolution No. 47-81.*

RESOLUTION 48-81

Resolution Regarding Physician Surplus and State of Ohio Medical School Enrollment

The Committee heard extensive testimony including a suggestion for alternative methods of medical school financing other than capitation. The testimony overwhelmingly supported rejection. Reasons included that this resolution might appear as selfish protectionism and it did not address the role of nonphysician health care providers nor the regulation of foreign medical school graduates. Accordingly, Resolutions Committee No. 3 recommends



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that Resolution 48-81 be *not* adopted. Mr. President, I so move.

By official action, *the House voted to reject Resolution 48-81.*

RESOLUTION 52-81

Comprehensive Health Education in Ohio Schools

Favorable testimony was presented for this resolution and the Committee received two additional RESOLVEDS relating to increasing physician participation at the local level and to increasing State support to local schools. Accordingly, Resolutions Committee No. 3 offers the following amended Resolution:

AMENDED RESOLUTION 52-81

Comprehensive Health Education in Ohio Schools

WHEREAS, The House of Delegates of the Ohio State Medical Association at the 1974 Annual Meeting adopted Amended Resolution 37-74 which stated:

"RESOLVED, That the Ohio State Medical Association urge the Ohio Department of Education and Ohio School Boards Association to offer comprehensive health education for all Ohio public school students from kindergarten through the twelfth grade; AND BE IT FURTHER

"RESOLVED, That the Ohio State Medical Association offer its support to the Ohio Department of Education and the Ohio School Boards Association in organizing the curriculum for this program, and providing to the Ohio Department of Education and the Ohio School Boards Association, upon request, assistance in development of teaching personnel and instruction."; and

WHEREAS, The Ohio State Medical Association continues to support comprehensive health education; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association reaffirms Amended Resolution 37-74; AND BE IT FURTHER

RESOLVED, That physicians be encouraged to seek election to local boards of education and/or become active as medical advisors to local boards of education in order to provide vital "grassroots" support at the policy-making level to develop and continue K-12 comprehensive health education programs; AND BE IT FURTHER

RESOLVED, That OSMA through its Committee on School Health communicate to the State Superintendent of Public Instruction and the President of the State Board of Education that increased support and consultative services be provided to local school districts to assist in creating and implementing effective comprehensive health education programs. Accordingly, Resolutions Committee No. 3 recommends *adoption* of Amended Resolution 52-81 and, Mr. President, I so move.

By official action, *the House voted to adopt Amended Resolution 52-81.*

RESOLUTION 61-81

Resolution on FTC

Favorable testimony was given and the Committee offers the following Amended Resolution:

AMENDED RESOLUTION 61-81

Resolution on FTC

WHEREAS, Medicine and other professions have a long tradition of self-regulation in the public interest; and

WHEREAS, The states have historically complemented this self-regulation with highly satisfactory, adequate, and effective licensing, monitoring, and enforcement activities; and

WHEREAS, Notwithstanding that record of responsible and successful combined regulation at the state level, the Federal Trade Commission has, without authority from Congress, increasingly interfered with professional activities and preempted state laws relative to the professions; and

WHEREAS, Ohio's Second District representative, Tom Luken, has introduced legislation to place a moratorium on activities of the Federal Trade Commission with respect to certain professions and professional associations; a moratorium which would stop this interference by the FTC; THEREFORE BE IT

RESOLVED, That the Ohio State Medical Association support the bill limiting the Federal Trade Commission's activities toward professionals; AND BE IT FURTHER

RESOLVED, That the Ohio delegation introduce a resolution at the June 1981 Annual Meeting of the AMA House of Delegates calling on the AMA to support similar legislation.

Accordingly, Resolutions Committee No. 3 recommends that Amended Resolution 61-81 be *adopted* and, Mr. President, I so move.

By official action, *the House voted to adopt Amended Resolution 61-81.*

RESOLUTION 49-81

Abolition of Mandatory Premarital Serology Testing

The Committee placed Resolution 49-81 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, The Chief of the Bureau of Preventive Medicine of the Ohio Department of Health, Dr. Halpin, states that it is impossible to defend premarital serologies; and

WHEREAS, In 1979, from the 159,627 premarital serologies performed, only three (3) primary or secondary cases of syphilis were found at a cost of at least $500,000, but probably closer to $1,000,000 per case; and

WHEREAS, A more beneficial measure for control of congenital syphilis is through well-timed prenatal testing, which is, in fact, already a mandatory part of Ohio law, and is directed not only at those who are married, but at the unmarried as well; and

WHEREAS, Recognition of these factors has caused many other states to repeal or begin re-evaluation of their premarital testing laws; therefore be it

RESOLVED, That the Ohio State Medical Association encourage development of legislation to abolish those state laws which make screening for syphilis a premarital requirement in Ohio.

By consent, *the House adopted Resolution 49-81.*

RESOLUTION 50-81

"PAP Smear" Law

The Committee placed Resolution 50-81 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, In 1977, the House of Delegates of the Ohio State Medical Association adopted Resolution 65-77 which states, "RESOLVED, That the OSMA work for repeal of Amended House Bill 1000 because of medical-legal, administrative, and third-party coverage problems, but that OSMA strongly urges the continuation of uterine cytologic examinations for women over the age of 18 years"; therefore be it

RESOLVED, That the Ohio State Medical Association continue to support legislative efforts to repeal the "Pap Smear" law in Ohio.

By consent, *the House adopted Resolution 50-81.*

RESOLUTION 51-81

Resolution to Teach Bioethics in Ohio Medical Schools

The Committee placed Resolution 51-81 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, Bio-medical technology and bio-medical research have raised significant moral questions, both in clinical and research medicine; and

WHEREAS, Our physicians are faced with legal and ethical decisions in their practice; and

WHEREAS, Bio-ethics has matured to a sufficient degree that specific assistance is now available to both physicians and researchers to resolve both ethical and moral questions; and

WHEREAS, There is a growing trend on the national level to require bio-ethics as part of continuing medical education (example, State of Michigan); and

WHEREAS, Medical students are the physicians of tomorrow and should be in a position to handle ethical and legal questions in the practice of medicine; therefore be it

RESOLVED, That the Ohio State Medical Association recommend that bio-ethics be included in the curricula of medical schools in the State of Ohio.

By consent, *the House adopted Resolution 51-81.*

RESOLUTION 53-81

Confidentiality of Quality Assurance Program Information

The Committee placed Resolution 53-81 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, Under present requirements of the Joint Commission on Accreditation of Hospitals, each hospital must establish a Quality Assurance program and committee activities to qualify for certification; and

WHEREAS, The present statute of the State of Ohio covers only Tissue Committee, Utilization Review Committee and Credentials Committee (O.R.C. 2305.24); and

WHEREAS, The delicate nature of material and information gathered by the quality assurance activities must remain free from discovery to permit efficient and proficient operation of this program; and

WHEREAS, There has been no case law directed to this problem; therefore be it

RESOLVED, That the Ohio State Medical Association extend to the State Legislature in the strongest possible terms, a need for legislation to insure that information of this committee and program remain secure and free from discovery; and be it further

RESOLVED, That this resolution be sent to the American Medical Association for national consideration of the matter.

By consent, *the House adopted Resolution 53-81.*

RESOLUTION 54-81

Voluntary Health Planning at the Local Level

The Committee placed Resolution 54-81 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

WHEREAS, The future of government directed health planning as envisioned in P.L. 93-641, as amended is uncertain; and

WHEREAS, Physicians are for orderly health planning; and

WHEREAS, Previous OSMA policy has favored health planning at the local level; therefore be it

RESOLVED, That physicians continue to involve themselves in voluntary health planning at the local level.

By consent, *the House adopted Resolution 54-81.*

RESOLUTION 55-81

Tax and Catastrophic Health Insurance

The Committee placed Resolution No. 55-81 on the Consent Calendar and recommended its rejection.

By consent, *the House rejected Resolution No. 55-81.*

RESOLUTION 56-81

Catastrophic Health Insurance

The Committee placed Resolution No. 56-81 on the Consent Calendar and recommended its rejection.

The House voted the resolution be taken off of the consent calendar, discussed it, then rejected Resolution No. 56-81.

RESOLUTION 57-81

N.W. Ohio Hospitals vs. The Health Planning Association of N.W. Ohio

The Committee placed Resolution No. 57-81 on the Consent Calendar and recommended its rejection.

By consent, *the House rejected Resolution No. 57-81.*

THE REPORT OF RESOLUTIONS COMMITTEE NO. 3, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

Dr. Thomas thanked the Committees and the House.

UNFINISHED BUSINESS

Report B, on interim sessions, etc., was carried over to the 1982 Annual Meeting.

The House applauded Dr. Thomas for his presiding ability in chairing the 1981 House of Delegates sessions.

Dr. Stanley J. Lucas, Hamilton County, moved a vote of thanks to Drs. Metzger, Sudimack and Zollinger as Resolutions Committee Chairmen. The motion was adopted by acclamation.

The House commended Gail Dodson for the excellent arrangements and operation of the 1981 Annual Meeting in Cleveland and complimented all members of the OSMA staff for their efficiency.

The House also commended Dr. John P. Anderson, Jr., Licking County, Chairman of the Nominating Committee and the Members of the Nominating Committee for their well-organized report and clear presentation.

INAUGURAL CEREMONY

Dr. Thomas introduced Dr. Thomas W. Morgan, Immediate Past President.

Dr. Frank H. Mayfield, Cincinnati, escorted Mrs. Dunsker and their daughter Sheila to the podium to join Dr. Dunsker.

Dr. Morgan administered the Presidential Oath of Office to Dr. Dunsker.

Dr. Dunsker then introduced his family, including his mother and aunt, to the House.

Dr. Thomas presented to Dr. Dunsker the official gavel and the President's Medallion.

Dr. S. Baird Pfahl, Jr., Sandusky, escorted Mrs. Thomas to the podium.

Dr. Dunsker presented to Dr. Thomas, the past president's pin, the president's plaque, replica of president's medallion to Mrs. Thomas and replica of president's medallion to Dr. Thomas.

Dr. Dunsker addressed the House.

There being no further business, the House of Delegates then adjourned, *sine die.*

ATTEST: Hart F. Page, CAE
Executive Director
and
Carol C. Maddy
Assistant Secretary
House of Delegates

Leukemia Society announces grant program

The Leukemia Society of America is now accepting applications for 1982 grants to support research in the fields of leukemia and related disorders. Three types of awards are being offered individual investigators whose work is concentrated on uncovering the cause or cure for leukemia, the lymphomas and Hodgkin's disease.

- Five-year scholarships, for a total of $125,000, are available for researchers who have demonstrated their ability to conduct original investigations in the specified fields.
- Two-year special fellowships, for a total of $37,000, are available for those in the intermediate stage of career development.
- Two-year fellowships, for a total of $30,000, are available for those in the entry stage of their career development.

All candidates must hold a doctoral degree, but may not have attained the tenured status of associate professor.

The deadline for filing applications is September 1, 1981. Application forms and further information may be obtained by writing to: The Leukemia Society of America, 800 Second Avenue, New York, N.Y. 10017.

Where is John Cameron Swayze when you need him?

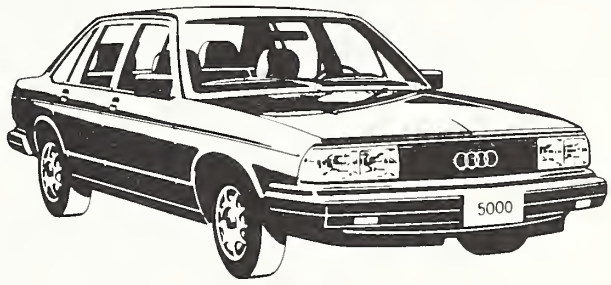
Elliot B. Duboys, M.D., of Stony Brook University recently recounted the following incident in a recent issue of the *Journal of the American Medical Association:*

"A 49-year-old New Yorker, attacked by a mugger, put his new Timex self-winding wristwatch with synthetic band and buckle into his mouth for safe-keeping. He swallowed the watch.

Some time later, the man was admitted to a hospital for treatment of another health problem. Routine x-rays revealed clearly the presence of the watch. There was no discomfort. Relatives gave consent for surgery and the watch was removed — intact and ticking. The date and time were incorrect — but it was not known if the setting had been correct at the time of the swallowing."

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—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

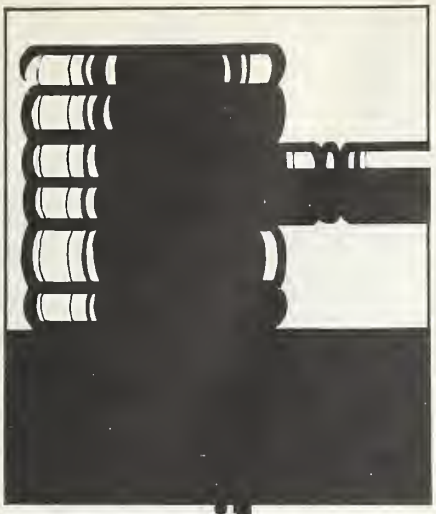
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6/80



council proceedings

PROCEEDINGS OF THE COUNCIL

May 21, 1981

A regular meeting of the Council of the Ohio State Medical Association was held Thursday, May 21, 1981, at Stouffer's Inn on the Square, Cleveland, Ohio.

Those present were: Stewart B. Dunsker, M.D., Cincinnati; C. Douglass Ford, M.D., Toledo; Robert G. Thomas, M.D., Elyria; David A. Barr, M.D., Lima; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; Benjamin H. Reed, M.D., Delta; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; Joseph L. Kloss, M.D., Akron; W. J. Lewis, M.D., Dayton; Oscar W. Clarke, M.D., Gallipolis; and James E. Pohlman, Esq., Columbus.

Those present from the OSMA staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; Robert E. Holcomb; Gail E. Dodson; Richard A. Ayish; Rebecca J. Doll; Carol W. Mullinax; David W. Pennington; David C. Torrens; Michael L. Bateson; and Lou Saslaw.

The meeting was called to order by President Dunsker. He conveyed thanks to the Cleveland Academy of Medicine for its assistance with the annual meeting and to the OSMA staff.

By official action, the President's committee appointments for 1981-1982 were confirmed.

Dr. Dunsker was authorized to cast the OSMA votes at the PICO shareholders' meeting of May 21, 1981.

Dr. Abromowitz presented a progress report on his committee's study of "participating agreements."

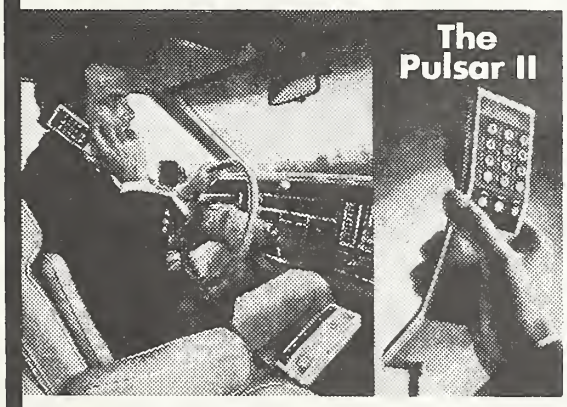
Mr. Ayish reviewed legislative developments at the State House with regard to the budget, abortion, hospital licensure, immunity for team physicians, and medical licensing board.

Dr. William Dorner was appointed to chair a committee which will study the committees of the OSMA, with regard to maximum participation of the members, and efficient operation.

The Council was reminded that the consensus was in favor of discontinuing the "November Update" meeting in 1981.

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CONTINUING EDUCATION PROGRAMS

RECENT ADVANCES ON THE DIAGNOSIS AND TREATMENT IN HEART DISEASE: September 24-25; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 14 credit hours; fee: $120, $80 for residents; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

ULTRASOUND, COMPUTED TOMOGRAPHY AND INTERVENTIONAL RADIOLOGY: September 30-October 2; Westin Hotel, Cincinnati; sponsor: University of Cincinnati Medical Center, Department of Radiology; 21 credit hours; fee: $240; contact: Robert A. Clark, M.D., Department of Radiology, 234 Goodman St., Cincinnati 45267, phone: 513/872-4396.

PEDIATRICS FOR THE PRACTICING PHYSICIAN: October 2-3; sponsor: Medical College of Ohio; co-sponsors: Northwest Ohio Pediatric Society and Ohio Chapter, American Academy of Pediatrics; 12 credit hours; fee: $150; contact: James Lustig, M.D., St. Vincent Hospital and Medical Center, 2213 Cherry Street, Toledo 43608.

MIDWEST FORUM ON ALLERGY: October 2-4; Stouffer's Inn on the Square, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 14 credit hours; contact: Joseph Kelley, M.D., Cleveland Clinic, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-6816.

RESPIRATORY CARE UPDATE: October 5-7; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 15 credit hours; fee: $150, $75 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

5TH ANNUAL BETHESDA HOSPITAL EXTRA-CAPSULAR CATARACT & IMPLANT SEMINAR: August 21-22; Westin Hotel at Fountain Square, Cincinnati; sponsor: Bethesda Hospital, Cincinnati; 16 credit hours; contact: Thomas O'Connor, Bethesda Hospital, 619 Oak St., Cincinnati 45206, phone: 513/559-6337.

PEDIATRIC GYNECOLOGY: September 2-3; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 13 credit hours; fee: $120, $80 for students or physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

USING LASER IN GLAUCOMA: September 12; Vernon Manor Hotel, Cincinnati; sponsor: Bethesda Hospital, Cincinnati; 8 credit hours; contact: Thomas O'Connor, Bethesda Hospital, 619 Oak St., Cincinnati 45206, phone: 513/559-6337.

NEUROLOGICAL APPROACH TO DEVELOPMENTAL DISORDERS: September 16; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: $50, $35 for students or physicians- in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

Marijuana and cancer

The National Cancer Institute (NCI) recommends that the active ingredient in marijuana, delta-9-tetrahydrocannabinol (THC), be made available to cancer patients who suffer from severe nausea and vomiting associated with chemotherapy, according to a report in a recent issue of the *Journal of the American Medical Association*.

In six out of seven studies involving 389 patients, THC was superior in treating cancer patients who were not helped by standard antinausea drugs, the NCI reports. In one study, THC was found equal to a major tranquilizer in effectiveness.

THC's action against nausea and vomiting was most pronounced when patients experienced a "high." A high can begin 20 to 60 minutes after the drug is taken and can last from one to five hours.

The high associated with THC involved mood changes (easy laughing, elation, and heightened awareness), mildly disordered fine motor coordination, and some distortion of activities and interactions with others. Sleepiness was another common side effect.

A few patients exhibited more severe consequences however, including visual hallucinations, anxiety and depression, coordination problems, abnormal sensations, rapid heart rate, and low blood pressure.

Obituaries

DOW LORENZO ALLARD, M.D., Portsmouth; University of Louisville School of Medicine, 1924; age 84; died March, 1981; member OSMA and AMA.

JAMES S. CALDWELL, M.D., Cincinnati; University of Cincinnati College of Medicine, 1931; age 76; died March, 1981; member OSMA and AMA.

HOWARD M. GANS, M.D., Cleveland; Ohio State University College of Medicine, 1927; age 80; died April 10, 1981; member OSMA and AMA.

JOHN R. KELKER, M.D., St. Cloud, Minnesota; Case Western Reserve University School of Medicine, 1928; age 80; died March 23, 1981; member OSMA and AMA.

DUANE D. LOVE, M.D., Sandusky; Ohio State University College of Medicine, 1938; age 68; died April 15, 1981; member OSMA and AMA.

ELSA SHAPIRA, M.D., Youngstown; Deutsche University School of Medicine, Praha, Czechoslovakia, 1939; age 66; died April 9, 1981; member OSMA and AMA.

JAI KUMAR SINGH, M.D., Cleveland; Medical College, Tirunelveli, Madras, India, 1958; age 47; died April 9, 1981; member OSMA and AMA.

HUSEYIN A. TURKOGLU, M.D., Columbus; University Istanbul, Turkey, 1947; age 59; died April 23, 1981; member OSMA and AMA.

JOHN B. ZIEGLER, M.D., Marysville; Ohio State University College of Medicine, 1955; age 67; died April 13, 1981; member OSMA and AMA.

Correction

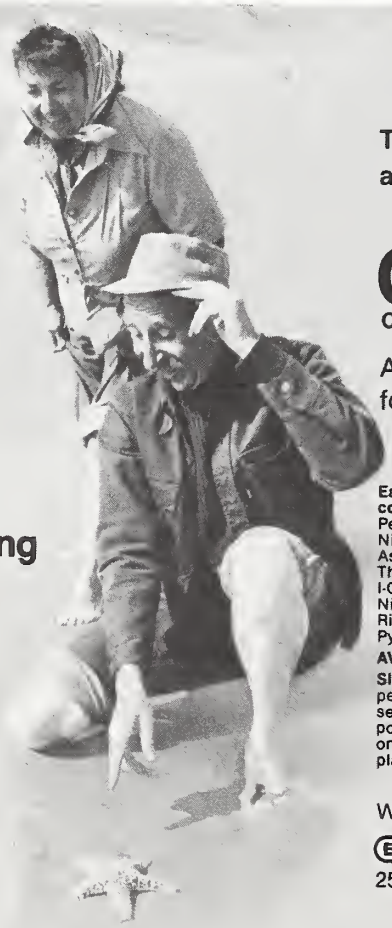
Last month, the following obituary ran in the *Journal* incorrectly:

VALENTIN F. MERSOL, M.D., Cleveland; Loyola University Stritch School of Medicine, 1959; age 87; died February 16; member OSMA and AMA.

The obituary should have read:

VALENTINE F. MERSOL, M.D., Cleveland; Universita Katerinsha, Praha, Czechoslovakia, 1924. The remainder of the obituary ran correctly.

The *Journal* apologizes for the error and for any confusion it may have caused.



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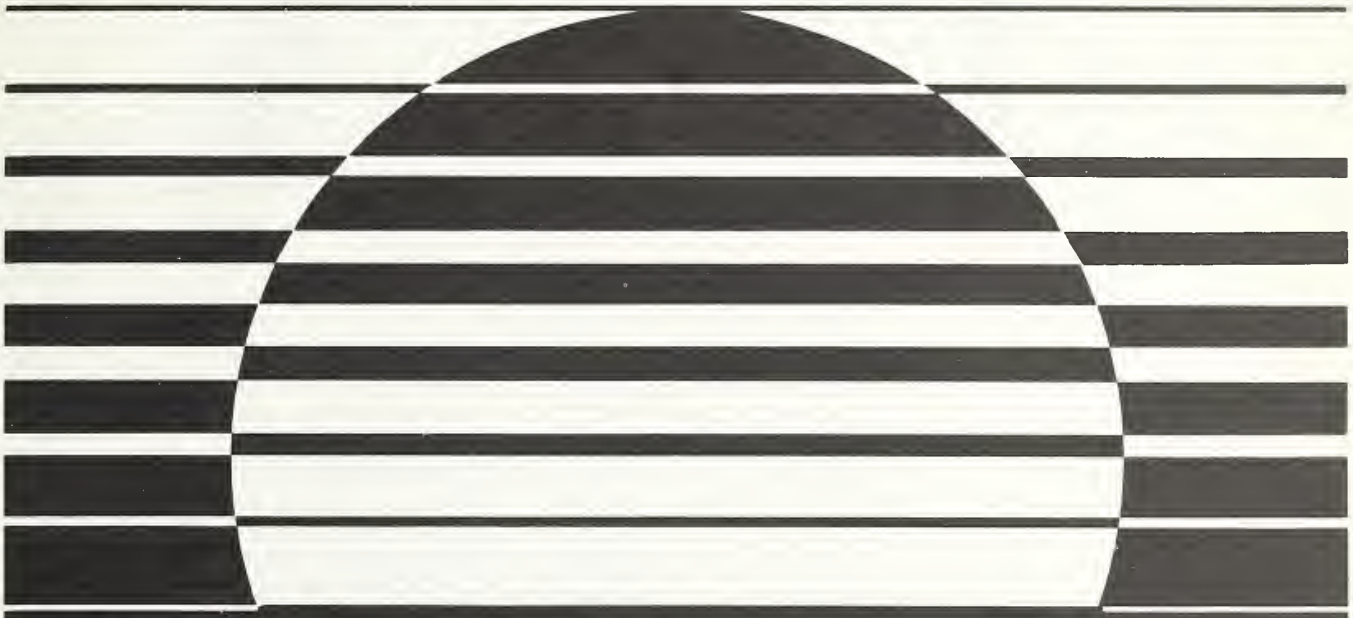
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WARNINGS:

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Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies; patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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Medical Crossword

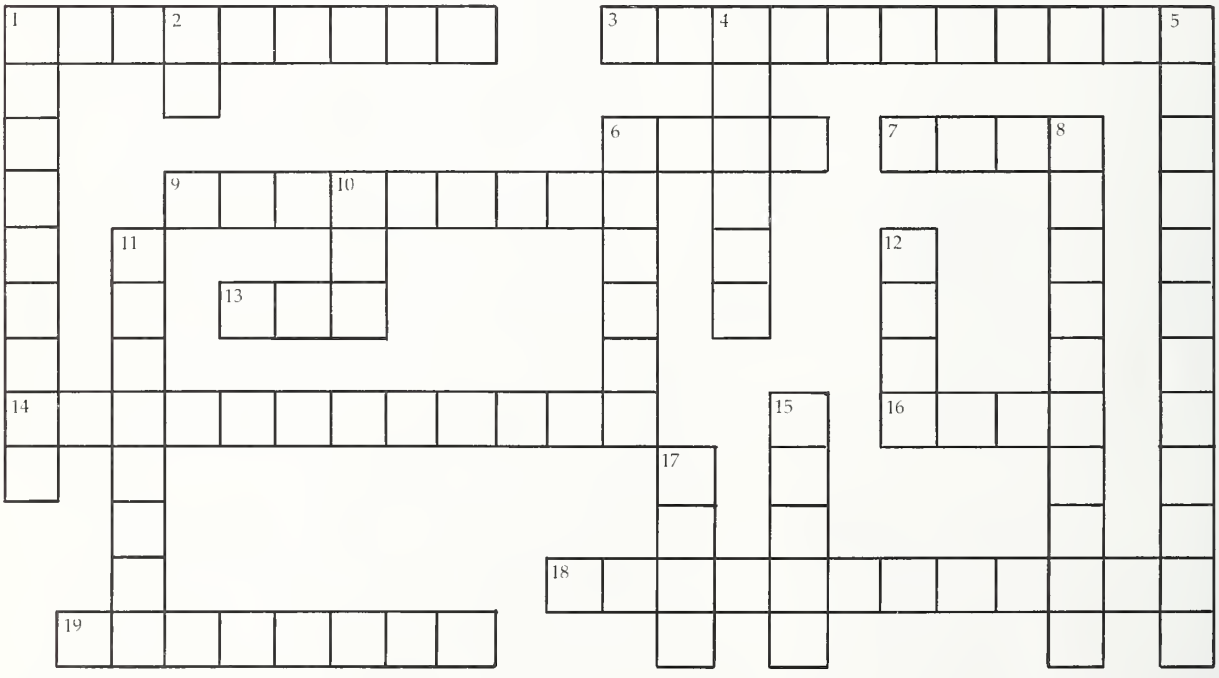
PITUITARY

ACROSS:

1. Pituitary hormone influencing lactation.
3. Where TRH and GnRh originate.
6. (Abbr) Hypothalamic decapeptide controlling LH and FSH secretion.
7. ____phil - anterior pituitary cells containing ACTH and LH.
9. Pituitary lobe derived from the CNS.
13. Pituitary hormone stimulating ovary follicle growth.
14. Embryological precursor of anterior pituitary.
16. (Abbr) CNS neurotransmitter precursor.
18. Pituitary hormone assisting renal concentrating ability.
19. Pituitary segment stimulated by hypothalamic releasing hormones.

DOWN:

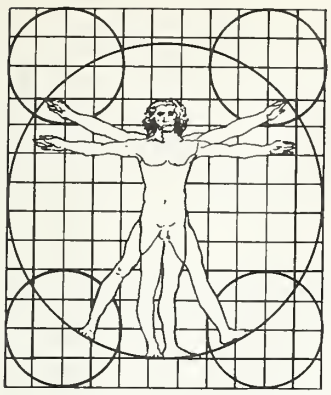
1. The master gland.
2. Pituitary hormone stimulating testosterone production.
4. Special circulation between the hypothalmus and pituitary.
5. Bony home of the pituitary.
6. Pituitary hormone generating somatomedin.
8. Its rise in serum increases ADH secretion.
10. Pituitary hormone regulating thyroxine levels.
11. Posterior pituitary hormone controlling uterine contractions.
12. ____back (pituitary target organ cooperation).
15. ____phil - anterior pituitary cells containing GH and prolactin.
17. Pituitary hormone controlling cortisol synthesis.



(C.R.M. Benson, (MD)

Robert M. Benson, M.D., an OSMA member, practices pediatric endocrinology in Summit County, and designs medically related crossword puzzles in his spare time.

(answers are on page 459)



CLINICAL & SCIENTIFIC

SUDDEN HEARING LOSS

Alan J. Sogg, M.D.

Sudden hearing loss is defined as the sudden onset of sensorineural hearing loss which is unilateral in the great majority of cases. The usual etiologic causes and modes of therapy and some controversies are discussed.

SUDDEN HEARING LOSS (SHL) has been a recognized disease entity since it first was described by DeKleyn[1] in 1944.

This one condition may have dozens of different etiologic causes. Mumps, with or without parotitis, encephalitis, measles, syphilis, multiple sclerosis, trauma, Meniere's disease, and acoustic neuroma compose only a partial list of conditions that have been proven to cause SHL. There is an equal sex distribution and the condition usually occurs after 20 years of age.

The histopathology of the common viral groups has been well described by Schuknecht[2,3] and include atrophy of the organ of Corti and of the tectorial membrane of the inner ear. The temporal bone specimens used by Schuknecht came from patients who died of other problems, as SHL itself does not cause death.

Presumably, the vascular causes of SHL can be from embolic phenomena, hypercoagulation as the result of a viral disease or "blood sludging" as proposed by Fowler.[4] The histopathology of these conditions shows bony new growth in the cochlea.[5]

Breaks in the various intracochlear membranes have been described as also causing SHL due to changes in the inner ear chemical balance or from disturbance of the vibratory energy created in the inner ear by extrinsic sounds.

In addition to inner ear membrane ruptures, breaks in the membrane of the round window which separates the middle ear from the inner ear have been described following sudden middle ear pressure changes such as scuba diving, trauma to the external ear, or sudden rise in intracranial pressure.

The treatment of SHL varies depending upon the etiology and it also must be noted that there is no uniformity of opinion as to what is the best treatment, if indeed, any. If SHL is truly idiopathic, nonspecific measures such as rest and avoidance of strain are employed.

Proven or presumed viral infections can be treated with anti-inflammatory agents.

Vascular problems can be managed by appropriate vasodilator or anticoagulant therapy.

Round window rupture or a labyrinthine fistula is treated surgically. Inner ear membrane ruptures currently are not being treated surgically.

The majority of patients (approximately 60%) recover fully or have only a mild to moderate residual hearing loss in the affected ear. At this point in time there have been no definitive studies to either prove or disprove the various modes of treatment.

SHL is a nonfatal condition of varied causes resulting in a sensorineural hearing loss that spontaneously resolves and leaves satisfactory or normal hearing on the affected side in approximately 60% of cases. Various therapies have been recommended in the past by different authors, but no uniformity of type or even the efficacy of therapy exists.

Dr. Sogg, Cleveland, Assistant Clinical Professor, Case Western Reserve University School of Medicine.
Submitted December 2, 1980.

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Employment Opportunities

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Managing depression in the cancer patient

A properly educated family can ease the alienation that a cancer patient feels as friends and associates begin to withdraw, states Richard J. Goldberg, M.D., in a recent issue of the *Journal of the American Medical Association*.

While medical factors can only be handled by the primary physicians, the psycho-social factors of depression in cancer patients can be faced by all concerned family members and friends, the article continues.

"Since the main burden falls on the spouse and family," Dr. Goldberg writes, "the physician should see them as a powerful ally and help to educate them and offer guidance. Family members should help the patient deal honestly with his feelings, rather than saying, 'Cheer up, you'll get over it!'"

COLLEAGUES IN THE NEWS



A. Burton Payne, M.D., chairing the board at PICO Life . . .



. . .while William M. Wells, M.D., chairs the board at PICO.

WILMA F. BERGFIELD, M.D., Chagrin Falls, was elected to the Cleveland Academy of Medicine's board of directors. Dr. Bergfield is head of the section of dermatopathology in the Cleveland Clinic Foundation's department of dermatology.

EDMUND C. CASEY, M.D., Cincinnati, is president of the American Lung Association. Dr. Casey is assistant clinical professor of medicine at the University of Cincinnati College of Medicine.

ELLIOT DAVIDOFF, M.D.,Newark, was appointed clinical assistant professor at Ohio State University in the department of ophthalmology.

JOHN R. DONOHOO, M.D., Georgetown, was named assistant clinical professor of family medicine at the University of Cincinnati College of Medicine. Dr. Donohoo also serves as director of medical services at Brown County General Hospital and Health Center.

The Distinguished Service Award was presented to **CHARLES E. JAECKLE, M.D.,** Defiance, by the Ohio Ophthalmological Society. Dr. Jaeckle is assistant clinical professor of ophthalmology at the Medical College of Ohio at Toledo.

LEONARD JANCHAR, M.D., was elected president of the Marion Academy of Medicine. Dr. Janchar is a pediatrician at the Smith Clinic, and serves as physician for Ridgedale High School football team.

A. BURTON PAYNE, M.D., Ironton, was elected chairman of the board of PICO Life Insurance Company. He has served on the board of the parent company, PICO, as chairman of its executive committee. Dr. Payne is an anesthesiologist and is the plant physician for Dayton Malleable, Inc. He is Councilor for the Ninth District of OSMA.

LEONARD P. ROME, M.D., Cleveland, received Mt. Sinai Medical Center's Julius E. Goodman Award. Dr. Rome was described as "the epitome of an outstanding physician, a great teacher, and a great human being." Dr. Rome is a pediatrician and serves on the boards of the Jewish Community Federation, Jewish Children's Bureau, and Bellefaire.

IRVING H. SCHROTH, M.D., Cincinnati, was honored for 51 years as a member of Christ Hospital's active medical and dental staff. Dr. Schroth is a member of the attending staff in internal medicine.

MELVIN SHAFRON, M.D., Cleveland, is the chairman of the long-range planning committee of the Neurosurgical Society of America.

O. DAVID SOLOMON, M.D., Cleveland, was elected to the board of trustees of the Diabetes Association of Greater Cleveland, and was appointed assistant clinical professor of ophthalmology at Case Western Reserve University School of Medicine.

M. E. SORRELL, M.D., Warren, was named director of medical affairs of Trumbull Memorial Hospital. Dr. Sorrell has served as president of the medical staff since December 1980.

ABBOTT G. SPAULDING, M.D., Cincinnati, was installed as president of the Ohio Ophthalmological Society. Dr. Spaulding is a clinical professor of ophthalmology and director of the eye pathology laboratory in the department of ophthalmology at the University of Cincinnati College of medicine.

MANUEL TZAGOURNIS, M.D., Columbus, was appointed dean of The Ohio State University College of Medicine. Dr. Tzagournis is professor of endocrinology at Ohio State University. He has authored approximately 52 medical research articles and publications, and is affiliated with nearly 20 professional associations and societies.

C. MICHAEL THORNE, M.D., Newark, was elected president of the Ohio Society of Pathologists. Dr. Thorne is director of the laboratory at Licking Memorial Hospital.

WILLIAM M. WELLS, M.D., Newark, was elected chairman of the board of Physicians Insurance Company of Ohio. He has served on the company's board since its inception in 1976, has been the company's vice chairman, and has served the company as chairman of the board of its subsidiary, Professionals Insurance Company. Dr. Wells was President of the OSMA in 1977-1978.

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Presidential nominee



Robert N. Smith, M.D.

President Ronald Reagan announced recently that he has nominated **ROBERT N. SMITH, M.D.,** Toledo, as assistant secretary of defense for health and environment, the nation's top military medical post. Dr. Smith held the same post during the Ford Administration.

The appointment, which must be confirmed by the Senate, will make Dr. Smith the senior health care official in the Department of Defense. He will be responsible for coordinating all health care policy for the armed forces, and will oversee a military health care system involving more than 180 hospitals around the world and thousands of physicians, nurses and allied health personnel. He also will be in charge of a more than $500 million-a-year insurance operation which reimburses military retirees for health care services they receive from civilian doctors in locations lacking regular Defense Department medical facilities. The post carries a military rank equivalent to that of a four-star general.

A past president of the OSMA and currently vice-chairman of the Ohio Delegation to the American Medical Association House of Delegates, Dr. Smith is a graduate of West Point and holds a degree in engineering from the Massachusetts Institute of Technology. His medical degree is from the University of Nebraska.

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by Karen S. Edwards

Hospitals retain rights to limit their services

A recent court decision, rendered by the Butler County Court of Common Pleas, has boosted the rights of private, nonprofit hospitals to limit the use of their radiological and laboratory services to Ohio-licensed medical physicians, osteopathic physicians, dentists and podiatrists who have been granted medical staff member or clinical privileges.

The policy, deemed "reasonable and lawful" by the court, was called in question when the hospitals received a letter, demanding that they change their policy to allow a doctor of chiropractic to use the facilities of the x-ray department.

In upholding the constitutionality of Section 3701.342 of the Revised Code, the court noted that the statute does not give the doctor of chiropractic the right to receive the services of the radiological or laboratory facilities of a private, nonprofit hospital. The court also recognized that the differences in the philosophies of those licensed as doctors of chiropractic versus those licensed as medical physicians, osteopathic physicians, dentists, and podiatrists could create an increasing risk of liability based on confusion and false impressions in the minds of patients and lack of understanding of the differences in treatment.

MISCELLANEA

• The National Cancer Institute has brought out two new publications, dealing with the subject of Diethylstilbestrol exposure in utero. A pamphlet, "Information for Physicians," answers questions physicians and patients are now asking, and, in addition, their "Atlas of Findings," now in press, will contain illustrations which will assist professionals in discovering the effects of this exposure. Both brochures are distributed free of charge and may be obtained by writing: National Cancer Institute's Office of Cancer Communications, Bethesda, Maryland 20205.

• The Juvenile Diabetes Foundation announces the availability of career development awards in diabetes research. Candidates must have a doctoral degree with four to seven years postdoctoral, clinical and/or research experience by the beginning of the award. The award has a three-year term with an annual review. Completed applications must be postmarked not later than October 1, 1981.

Meetings

Diagnostic Ultrasound in Obstetrics and Gynecology/ and in the Abdomen: September 10-11 and 12-13; Turner Auditorium Building, John Hopkins Medical Institutions, Baltimore, Maryland. The tenth in a series of ultrasound conferences, this year's talks will concentrate on how well ultrasound can answer clinical problems in obstetrics and gynecology and in the abdomen. Credit: 32 hours, Category I. For further information, please contact: Office of Continuing Education, 720 Rutland Ave., Rm. 19, Turner, Baltimore, Md. 21205

Midwest Cancer Seminar: September 17-19; Concourse Hotel, Madison, Wisconsin. Faculty from throughout the U.S. and Europe will participate in this seminar, directed toward physicians in primary care and oncology. For more information, please contact: Paul C. Tracy, M.D., Wisconsin, Clinical Cancer Center, 1900 University Ave., Madison, Wisconsin 53705.

Postgraduate Institute for Career Emergency Physicians: October 12-16; Detroit, Michigan. Oriented to provide important, clinical aspects and direct the physician to the proper evaluation and care of patients with urgent programs. For more information, contact: PICEP, Wayne State University School of Medicine, 9b-32 DRHUHC, 4201 St. Antoine, Detroit, Mich. 48201.

Seminar on Polynuclear Aromatic Hydrocarbons: October 27-29; Battelle Laboratories, Columbus, Ohio. The symposium will feature presentations on the toxicology, immunology and physical chemistry of polynuclear aromatic hydrocarbons. For further information, contact: Denise Cooley, Battelle's Columbus Laboratories, 505 King Ave., Columbus, Ohio 43201.

OSMA's reducing plan

New Annual Meeting format set for 1982

OSMA officers wasted no time in responding to the recent House of Delegates resolution calling for a shortened Annual Meeting format. The resolution, which passed at the 1981 Annual Meeting in May, proposed that future meetings run from Thursday through Saturday instead of the traditional Saturday through Wednesday. It was requested that the change be made as soon as possible.

At a meeting on June 8th, OSMA officers decided to put the plan into practice for the upcoming 1982 Annual Meeting. However, due to difficulties in making last-minute changes in accommodations, the 1982 meeting will not conform exactly to the resolution.

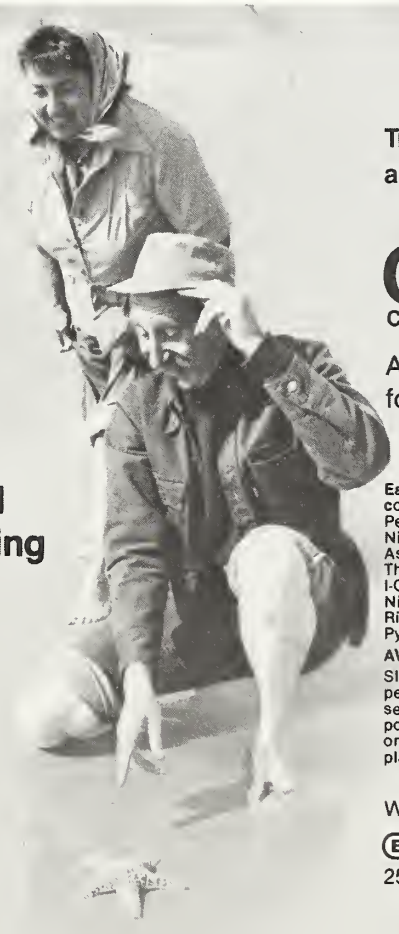
The schedule for the 1982 OSMA Annual Meeting to be held in Dayton is as follows. The House of Delegates will open on Friday, April 30th. Reference Committee hearings will be held Saturday, May 1st, with the final session of the House on Sunday, May 2nd. Scientific Sections and Specialty Societies will be invited to present scientific programs beginning Sunday afternoon, May 2nd, and running through Wednesday, May 5th, if necessary. The deadline for resolutions is Monday, March 1, 1982.

New drug to ease hypertension

A "revolutionary" new drug, designed to help patients suffering from hypertension, will be on the market soon, according to recent reports by the Food and Drug Administration.

The properties of the drug, captopril, were first found in the venom of the jararaca, a poisonous, South American snake. Scientists isolated the compound and synthesized it.

Jay Sullivan, M.D., Chief of the division of cardiovascular diseases at the University of Tennessee Center for the health sciences, call the drug "revolutionary," and said it was just a matter of time before captopril becomes the major drug in the war against hypertension.



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STATE

FOUR-MONTH INTERIM BUDGET APPROVED BY LEGISLATURE AFTER LONG DELIBERATION

House Bill 638 (Shoemaker, D-Bourneville) was adopted by both the Ohio House and Senate twenty-four hours into the state's new fiscal year. The interim budget will fund state services for four months, at a level three percent below current spending levels, except for public schools, welfare, and mental health. The legislature will reconvene to work on the biennium state budget, HB 167 (Shoemaker, D-Bourneville), after Labor Day.

The biennium budget passed both houses but stalled in conference committee. HB 167 contains three major provisions supported by the OSMA: 1) a legislative study commission, with three House and three Senate members, to examine current rates and timeliness of Medicaid reimbursement for physicians; 2) a continuing medical education "checkoff" system, similar to California's, which permits a physician, at the time of re-registration, to attest to completion of CME requirements, rather than the currently mandated mailing of CME logbooks to the Board for processing; and 3) a mandated forty-five-day turnaround on Medicaid claims, with provision for five percent interest paid on claims unpaid after forty-five days. Discussion between the House and Senate on HB 167 broke down when the House Democratic majority balked at the size and extent of the budget cuts (totalling $220 million) proposed by the Republican Senate. Agreement on the subsequently proposed interim budget came only after the Senate was promised the interim budget would be balanced, and the House was granted a four-month interim budget, instead of the two-month budget proposed by the Senate.

Ironically, the State of Ohio finished the fiscal year with nearly a quarter of a million dollars in the bank. As many Ohio physicians may already know, some of that "surplus" may include Medicaid claim funds, which were paid only occasionally in the last six weeks of the fiscal year. Ohio has a constitutional requirement that the state must be "in the black" at the close of the fiscal year, and holding back claim monies temporarily "balances" the state's budget. Medicaid payments resumed in early July.

It is hoped that the renewed budget talks scheduled for September will offer a more accurate perspective on the state's revenue profile as well as a better understanding of the federal government's funding intentions. Until that time, HB 167, which includes the OSMA-supported Medicaid and CME amendments remains inactive.

MEDICAL BOARD LEGISLATION PASSES HOUSE, 72-22

Legislation structured to increase the funding and staffing of the State Medical Board was approved by the House and sent to the Senate in late June. HB 317 (Thompson, D-Cleveland) grants the Board investigative subpoena power similar to some other state agencies, authorizes emergency license suspensions pursuant to clear and convincing evidence of a danger to the public, expedites appeals of Board orders, and protects the confidentiality of patient records and Board records. While the bill was being considered on the floor of the House, the OSMA worked successfully to defeat a major amendment to the bill which would require mandatory reporting to the Board of malpractice settlements and judgments, as well as any restriction placed upon individual physicians' hospital staff privileges. The OSMA has strongly opposed the mandatory reporting of malpractice settlements and judgments due to the fact that reporting of judgments and particularly settlements is not a solid indicator of physician competency. Last session, the OSMA successfully defeated a similar mandated malpractice reporting amendment that was sponsored by the State Medical Board. HB 317 has been referred to the Senate Health and Human Resources Committee.

OSMA-SUPPORTED CHILD RESTRAINT BILL INTRODUCED

Representative Lee Fisher (D-Shaker Heights) has introduced HB 605, which requires the use of child safety seat restraints for any child who (1) is under four years of age or (2) weighs less than forty pounds, whenever the child is a passenger in an automobile owned by the parent or legal guardian. Under the bill, which has been referred to the House Highways and Highway Safety Committee, violators would receive two penalty points against their drivers' licenses. These points would be removed either upon successful completion of a course in remedial driving instruction or upon purchase of a child restraint system that meets federal safety standards.

According to the Ohio Department of Highway Safety, automobile accidents accounted for almost 4,000 injuries and 32 deaths of children under the age of four in Ohio last year. The costs of these deaths and injuries last year in Ohio exceeded $30 million, according to the National Safety Council. Automobile accidents are the leading cause of childhood death and injury. It is believed that up to 90% of fatalities and serious injuries could be prevented by the proper use of safety seat restraints.

The life-saving potential of this legislation is clear, and both the OSMA and the Ohio Chapter of The American Academy of Pediatrics strongly support the bill. OSMA members should contact their state representatives and senators to urge support for HB 605.

BRAIN DEATH LEGISLATION HEARD IN HOUSE COMMITTEE

The AMA in conjunction with the American Bar Association, American Academy of Neurology, American Electroencephlographic Society, the National Conference of Commissioners on Uniform State Laws, and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research drafted a model bill to provide for the legal determination of death and submitted it to the states for adoption. The bill states, "An individual is dead if he has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the brain, including the brain stem, as determined in accordance with accepted medical standards."

The Ohio State Medical Association's House of Delegates at its 1980 Annual Meeting adopted a resolution directing the OSMA to actively support legislation based on this model. At the request of the OSMA Department of State and Federal Legislation, Senator Paul Matia (R-Westlake) introduced this legislation as SB 98. In late April, SB 98 passed the Ohio Senate. The bill has been referred to the House Judiciary Committee and has received two hearings to date. More hearings are expected in September when the legislature reconvenes. Physicians are encouraged to contact their state representative in support of SB 98.

DRUG IMPRINT LEGISLATION SIGNED BY GOVERNOR, EFFECTIVE OCTOBER 6, 1981

Legislation requiring manufacturers or wholesale distributors of dangerous drugs to imprint an identifying mark on all finished solid oral dosage forms of dangerous drugs was signed by the Governor on July 7, 1981. HB 135, supported by the OSMA, requires the manufacturer or wholesale distributor to supply the Ohio Board of Pharmacy with a description of all the company's imprints and the dangerous drugs on which they are printed. The legislation also requires the Board of Pharmacy to provide an updated composite list of imprinted drug logos to all poison control centers in Ohio.

TEAM PHYSICIAN BILL AWAITS GOVERNOR'S SIGNATURE

SB 259 (Kasich, R-Westerville) explicitly extends the protection of Ohio's Good Samaritan Act to team physicians, podiatrists and nurses who render emergency care to participants in a school athletic event, has been approved by both the House and Senate. The bill now awaits the Governor's signature enacting the legislation into law in 90 days.

SENATE-INFORMED CONSENT LEGISLATION IN SENATE RULES COMMITTEE

SB 315 would require a detailed informed consent prior to an abortion and establish juvenile court procedures by which a pregnant unmarried minor must obtain court consent to have an abortion. The bill has passed out of the Health and Human Resources Committee and now awaits scheduling for a floor vote. The House recently indefinitely postponed identical legislation (HB92) in the House State Government Committee.

STATE OFFICER IMMUNITY HEARD IN HOUSE CIVIL AND COMMERCIAL LAW COMMITTEE

SB 204 (Skall, R-Euclid) is legislation which would require the State of Ohio to provide representation, immunity and indemnification in civil actions for physicians and other health-related personnel who are sued by wards of the state arising from the delivery of such services.

The legislation was introduced at the request of the OSMA to help alleviate the continual problem of inmate nuisance suits against physicians who treat inmates of state institutions. Physicians who have a personal services contract or provide services at the request of an agency of the state will be covered by SB 204. The bill has passed the Senate and will be considered further in the House Civil and Commercial Law Committee.

FEDERAL

HOUSE PASSES BUDGET RECONCILIATION

On Friday, June 26, the House of Representatives handed President Reagan his biggest victory of the year with the passage of HR 3982, the Omnibus Budget Reconciliation Act of 1981, by a vote of 217 to 211. Action in the House was frantic with close votes on parliamentary procedures preceding final action on the actual budget bill late Friday.

BUDGET RULE

In one of the most decisive votes this year, 29 Democrats joined united House Republicans to turn back a Democratic leadership-sponsored rule to the reconciliation bill. It was another budget defeat for the majority leaders and a major boost for President Reagan. A conservative Democratic-Republican coalition voted 210-217 not to approve a rule that the leadership had hoped would be the right strategy to stop the Gramm-Latta II budget reconciliation amendment from being adopted. Ron Mottl (D-Cleveland) joined 28 other Democrats in opposing the leadership and helped give the House the ability to vote on Gramm-Latta as a single package.

During July the House and Senate conferees will attempt to reach a compromise on their respective budget packages and develop a proposal for the President's signature. Both bills cut the original FY 1982 budget by more than $39 billion.

An analysis of the provisions of the House and Senate bills is available, by request, from the Department of State and Federal Legislation.



SECOND OPINION

Routine Tests:
a costly convenience?

By Raman Shanker, M.D.

The Federal Government has accused physicians and American hospitals as a group for the escalating costs of medical care in our community. This may be considered by many as a sweeping and generalized accusation. But I would like to raise the question as to how many of us really think of costs in our day-to-day care of the patient. How often have we fallen into the habit of making an expensive test a routine one to save us from a hospital audit or a malpractice suit? How often have we used an expensive test or investigation as a substitute for a simple clinical evaluation? I think we certainly owe it to our community to look within ourselves to keep the costs down without sacrificing the quality and the outcome. I find that quite often the physician is guilty in this regard only because he did not take the time to stop and think of less costly alternatives. In many situations all it takes for us to fall out of this routine is for someone else to draw our attention to this wasteful problem.

Radiological examinations

Of all the expensive and unnecessary investigations, I think radiological examinations lead the list. Radiological examinations also are significant by the fact that they are potentially harmful to the patient in the long run. For instance, I question the habit of many physicians and hospitals' intensive care areas in routinely checking the position of the endotracheal tube by means of an additional chest x-ray. Obviously, the purpose of this is to rule out right endobronchial intubation. Anesthesiologists intubate several patients in the O.R., and routinely check for the clinical signs of bilateral breath sounds, etc., and convince themselves about the position of the tube. For the more inhibited ones who shy away from patient contact or the ones who question their own clinical acumen there is even a more simple and three dimensional way to check the position of the tube. I suggest placing another similar sized, calibrated E-Tube alongside and parallel to the intubated tube but outside the patient's oral or nasal cavity as the case may be. The position of the tip of the tube now can be visualized. This would cost the patient nothing, but on the other hand better information about the position of the E-Tube can be obtained almost instantly. At the end of every shift of the nurses these same measurements can be repeated.

Similar common sense maneuvers in checking the CVP lines may not be out of place. However, I do agree that under some circumstances these maneuvers may not be adequate and additional expensive investigations may be necessary. Also, since the advent of the CAT scan, many traditional radiological investigations have only become redundant. And yet avoidance of these redundant tests which could save a sizable expenditure for the community is often overlooked by many of us.

We should all make a concerted effort to reduce the escalating cost of medical care in a community. One way to spark the cost-consciousness of the medical profession would be to invite more physicians to come forward with similar suggestions in other areas of practice. OSMA

Raman Shanker, M.D., is a member of the OSMA, and practices anesthesiology in Columbus.

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy.

Two physicians join OSMA Council

Filling vacancies on the Ohio State Medical Association (OSMA)'s Council are Ben H. Reed, Jr., M.D. and Joseph L. Kloss, M.D.

Dr. Reed, Wauseon, Ohio, has been elected Councilor of the fourth district of the Ohio State Medical Association. As a member of the OSMA's governing board he will represent physicians from Defiance, Fulton, Henry, Lucas, Ottawa, Paulding, Putnam, Sandusky, Williams, and Wood counties.

Dr. Reed is currently on the staff at Fulton County Health Center and is also in general practice in Delta.

He has served as Fulton County Coroner for over 16 years and is currently President of the Northwest Ohio Chapter of the American Heart Association. He is also vice chairman of the Fourth Ohio district of the Professional Standards Review Organization.



Ben H. Reed, Jr., M.D.

Dr. Reed has been an active member of the Fulton County Medical Society, the OSMA and American Medical Association since 1954.

He received his medical degree from the University of Louisville, Kentucky.

Dr. Reed and his wife, Penny, have three children.

As Twelfth District Councilor, Dr. Kloss will represent physicians from Portage and Summit Counties.

Dr. Kloss is currently assistant professor of dermatology at the Clinical Northeastern Ohio School of Medicine. He was President of the Summit County Medical Society in



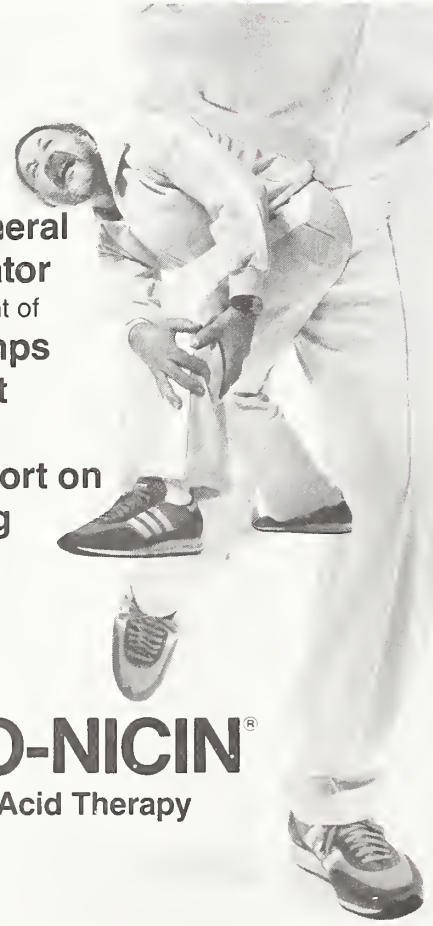
Joseph L. Kloss, M.D.

1979 and has been a Council member of the society since 1972.

Dr. Kloss received his medical degree from the St. Louis University of Medicine and is a Fellow of both the American Academy of Dermatology and the American Academy of Pediatrics.

He is a member of numerous organizations including the American College of Cryosurgery, the OSMA, the American Medical Association and the University Club of Akron.

Dr. Kloss and his wife Nina, have five children.



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AVAILABLE: Bottles of 100, 500.

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Ohio State Medical Golfers

In the swing of things

By Robert D. Clinger

Ralph R. Ballenger, M.D., Columbus, and Carlos E.F. Pena, M.D., Lorain, captured top honors in the 56th Ohio State Medical Golfers Association Tournament played on June 12 at the Country Club of Ashland.

Dr. Ballenger carded a one-over-par 73 to win the low gross championship. His name will be inscribed on the Richard P. Bell, M.D. Trophy. Dr. Pena took low net honors by recording a 77 minus a 13 handicap for a net score of 64. His name will be inscribed on the Dr. Ray Stephens Memorial Trophy.

Winners in age flights among the 120-member field were as follows:

- Low gross, age 39 and under — David M. Montgomery, M.D., Canton (81)
- Low net, age 39 and under — Scott A. McIlroy, M.D., Columbus (73)
- Low gross, age 49 and under — William M. Emery, M.D., Ashland (83)
- Low net, age 49 and under — Semur P. G. Rajan, M.D. Mansfield (70)
- Low gross, age 59 and under — John C. Stahler, M.D., Dayton (78)
- Low net, age 59 and under — James L. Secrest, M.D., Mansfield (70)
- Low gross, age 69 and under — C.T. Kasmersky, M.D., Columbus (80)
- Low net, age 69 and under — William A. White, Jr., M.D., Canton (68)
- Low gross, age 70 and over — H.C. Marsico, M.D., Lorain (99)
- Low net, age 70 and over — Gilman Kirk, M.D., Columbus (78)

Awards were presented during the annual banquet by C. J. Shamess, M.D., Mansfield, president of the OSMGA.

Dr. Shamess announced that the 1982 OSMGA Tournament will be played on Friday, June 11 at Marion Country Club, Marion. Site for the 1983 competition on June 10 will be Moundbuilders Country Club in Newark.







Top: Edward Sawan, M.D., Akron and Edward Zartman, M.D., Columbus, both members of the OSMGA Board of Directors, pose before a ride to the green.

Middle: James F. Mason, M.D., Columbus, begins his round. Bottom: Edward B. Young, M.D., Lima, prepares to tee off on No. 10.

Robert D. Clinger is a contributing editor of the Ohio State Medical Journal









All photos by Robert D. Clinger

Top left: Jerome A. Wensinger, M.D., Marion describes the flight of his ball to Samuel L. Portman, M.D., Columbus. Relaxing in the cart behind him are (l. to r.) Ralph Ballinger, M.D., and Scott McIlroy, M.D., both of Columbus. Top right, Carlos Pena, M.D., Lorain, flashes the victory sign, as he steps forward to receive his trophy for low-net honors. Bottom left: Low gross champion, Ralph Ballenger, M.D., Columbus, accepts his trophy from OSMGA President, C.J. Shamess, M.D. Bottom right: One of the day's foursome included (l. to r.) Andrew V. Boysin, M.D., Elyria; H. Boyd Cameron, M.D., Elyria; Gabriel A. Sabga, M.D., Lorain; and John B. McCoy, M.D., Elyria.

The Ohio State University
Center for Continuing Medical Education
announces

Fifth Annual Hypertension Symposium

A STEP IN THE RIGHT DIRECTION
The Stepped-Care Approach to Hypertension

Thursday, September 17, 1981
Rhodes Hall Auditorium
450 W. 10th Avenue
Columbus, Ohio 43210

SPONSORED BY: The Ohio State University College of Medicine Center for Continuing Medical Education, The College of Medicine, Departments of Family Medicine, Family Practice, and Pharmacology; The College of Pharmacy; and the Ohio Department of Health.

OBJECTIVES: The focus of this year's symposium is on the drug therapy of hypertension, with special emphasis on the stepped-care approach as recently revised by the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure.

Specific topics of discussion include: 1) scientific basis and rationale for the stepped-care approach; 2) description of the stepped-care approach and its use in treating patients to a goal blood pressure; 3) indications, mechanisms of action, side effects, and drug interactions of all major anti-hypertensive drugs currently under investigation; and 5) roles of the physician and pharmacist in the management of hypertension.

Free calibration checks of aneroid sphygmomanometers will be provided for all participants during the breaks.

VISITING FACULTY:
- Frank Douglas, M.D., Ph.D., Clinical Associate, National Heart, Lung and Blood Institute, National Institutes of Health, Bethesda, Maryland.
- Ray W. Gifford, Jr., M.D., Head, Department of Hypertension and Nephrology, Cleveland Clinic Foundation, Cleveland, Ohio.
- Ted L. Goodfriend, M.D., Associate Chief of Staff for Research, Veterans Administration Hospital, Madison, Wisconsin.
- R. Patterson Russell, M.D., Professor of Medicine; Director, Hypertension Unit, Johns Hopkins Hospital, Baltimore, Maryland.
- Cameron Strong, M.D., Professor of Medicine; Director, Multidisciplinary Hypertension Clinic, Department of Medicine, Mayo Clinic, Rochester, Minnesota.
- Peter H. Vlasses, Pharm. D., RPh., Assistant Director Clinical Pharmacology, Department of Clinical Pharmacology, Thomas Jefferson Hospital, Philadelphia, Pennsylvania.

THE OHIO STATE UNIVERSITY FACULTY:
- William H. Bay., M.D. Assistant Professor, Director of Dialysis, Department of Medicine, College of Medicine.
- Joseph R. Bianchine, M.D., Ph.D., Professor and Chairman, Department of Pharmacology; Professor, Department of Medicine, College of Medicine.
- Alan Escovitz, Ph.D., Assistant Director, Academic Studies in Pharmacy; Executive Secretary, Council of Ohio Colleges of Pharmacy, College of Pharmacy.
- Philip B. Hollander, Ph.D., Professor and Deputy Chairman, Department of Pharmacology; College of Medicine.
- Albert H. Soloway, Ph.D., Dean, College of Pharmacy.
- Manuel Tzagournis, M.D., Dean, College of Medicine.
- Tennyson P. Williams, M.D., Professor and Chairman, Department of Family Medicine, College of Medicine.

OHIO DEPARTMENT OF HEALTH
- Frank S. Bright, M.S., Project Director, Ohio Hypertension Control Program.
- Ester Lenhert, R.N., M.P.H., Nursing Supervisor, Ohio Hypertension Control Program.

CREDIT: As an organization accredited for continuing medical education, The Ohio State University College of Medicine Center for Continuing Medical Education certifies that this continuing medical education offering meets the criteria for 6 hours in Category 1 of the Physician's Recognition Award of the American Medical Association and the Ohio State Medical Association provided it is used and completed as designed.

This program is accepted for 6 prescribed hours by the American Academy of Family Physicians.

REGISTRATION: The registration fee of $30.00 includes lunch, coffee and all educational materials. Send registration fee on your letterhead to:

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An OSMA committee report

Teenage Pregnancies

A report of the Subcommittee of the OSMA Committee on Maternal and Neonatal Health, Edward E. Grable, M.D., Canton, Chairman

Each year about one out of ten teenagers becomes pregnant. This amounts to approximately 1 million pregnancies, of which approximately 600,000 are delivered at term. And the problem has been steadily increasing since 1960. Why? First of all, the total number of teenagers has steadily increased in the past two decades, although it now appears that the number of adolescents will decline about 4% annually until a stable population is reached in 1986 or 1987. Secondly, mores have changed, especially among those of Caucasian origin. Obviously, if premarital pregnancy is no longer considered anathema, an increase in same should not be considered unusual. A good example of this is that over 90% of all teenagers now keep their babies, compared to only about 20% in the late 1950s and early 1960s. It is not difficult to see wherein the changes have taken place, considering the fact that in the 1950s and 1960s only about 5% of those of Caucasian origin kept their infants. Perhaps at this point it might be well to note that approximately 40% of teenagers who are pregnant are married, while about 60% are not. While marriage does not totally remove the high risk factors in teenage pregnancies, it does substantially reduce the incidence.

For all practical purposes, let us confine our general remarks to the greater problem of the unmarried teenager. Despite the much easier availability of contraceptives, it appears that most teenagers have an aversion to same, many having the psychological attitude that somehow the use of mechanicai contraception cheapens intercourse. Another problem faced by the teenager is simply a lack of knowledge of such factors as the interpretation of the menstrual cycle, what is premature ejaculation and its relation to the production of a pregnancy, etc. Additionally, what motivation is present to avoid pregnancy? Obviously, if a teenager, boy or girl, is convinced that a pregnancy will result in obtaining an otherwise unattainable parental permission to marry, it becomes obvious that contraceptives under such circumstances simply will not be used.

While the psycho-social problems that can and frequently do result from teenage pregnancies indeed are serious, the medical problems are just as important — in many cases more so. Probably the most important is toxemia of pregnancy and its complications. While toxemia is essentially a disorder of primigravidas, the incidence in teenage pregnancies almost doubles — probably a result of poor nutrition or, at least, poor nutritional habits. In addition, low birth weight babies are common, probably both as a result of nutritional deficiencies plus smoking (which is two to three times as frequent in the pregnant versus nonpregnant teenager).

Therefore, what is the solution? Most of those in active contact with this problem believe that education is paramount — education beginning at age 11 or 12. Many will say, "Why so early?". A convincing answer could surely come from the fact that over 10,000 births in 1977 occurred in the under 15 age group!

Recognizing that education does appear to be the best answer, federal and state agencies have allocated ever-increasing amounts of money toward teenage sex education; in some cases, in the face of fairly strong parental opposition. While one cannot give exact figures, too many parents still cling to the "head-in-sand" approach that if nothing is done, the problem will somehow disappear! Nothing could be farther from the truth. Masters & Johnson's studies quite well documented the rather outstanding fact that 10% to 15% of teenagers who become pregnant know little or nothing about reproduction! Once a girl learns that a 2 A.M. feeding doesn't mean "Coke and pizza," perhaps her attitude toward sex may gradually change. Yet one must not lose sight of the fact that sexual drive reaches its peak in the female in the 15- to 18-year age group — and peaks in males 18 to 24 months later.

The question of abortion in teenage pregnancies frequently arises. Undoubtedly, the ease of attaining abortion has been a factor in the changing mores — but how much so, no true figures are available. But when one considers that about 50% to 55% of Americans are opposed to abortion in any form, plus an additional 20% to 25% who oppose abortion except when the life or the long-range health of the mother is involved, abortion as a control factor in teenage pregnancies is a sticky issue to say the least. Once again, education, education, and more education appears to be the best approach to this problem. OSMA

Chicago Report

By Oscar Clarke, M.D., and Stewart Dunsker, M.D.

This report covers some of the important issues voted on by the Ohio Delegation at the 1981 Annual Business Meeting of the American Medical Association in Chicago, June 7-11, 1981.

There were 78 reports and 156 resolutions considered by the House of Delegates. Three of the resolutions were introduced by the Ohio Delegation at the direction of the Ohio House of Delegates.

DIRECT AMA MEMBERSHIP

An Ohio resolution and a report of the Council on Long Range Planning and Development were considered together on the issue of the AMA providing for direct membership.

The Ohio resolution called for the House to affirm its support for the Federation concept for AMA, state and county membership and that direct AMA membership be permitted only where county and/or state membership are not available. The AMA would be further required to consult with the constituent state associations on direct members to confirm their validity.

The Council report recommended that direct membership in the AMA as a membership option be offered to physicians and that the Bylaws be amended accordingly.

The Council report was adopted in lieu of the Ohio resolution. **The Ohio delegation was unanimous in its opposition to this action. The Ohio delegation was unanimous in a losing effort to have the issue reconsidered.** The House, by a vote of 196-59, approved Bylaw changes providing for direct AMA membership.

The reference committee that considered this issue noted that the AMA will put its first emphasis on recruiting physicians through the federation in cooperation with state associations that want to join the AMA in a coordinated membership campaign. The AMA will underwrite part of the cost involved in soliciting **all** physicians in a state. The AMA also will **not** solicit direct members until May 1, seven months after state and county efforts to solicit members. The program is to be evaluated after three years.

FEDERAL TRADE COMMISSION

The House of Delegates, without debate, adopted the Ohio resolution calling for the AMA to support legislation limiting the Federal Trade Commission activities toward professionals.

THE RIGHT OF A HOSPITALIZED PATIENT TO CHOOSE HIS/HER ATTENDING OR CONSULTING PHYSICIAN

This Ohio resolution resolved that it be the policy of the AMA that nothing should preclude the right of a hospitalized patient to choose his/her attending or consulting physician, provided that the physician has privileges to practice and is qualified to perform required services in the hospital, and is willing to accept the patient.

The reference committee was not supportive of the resolution, citing violations of FTC regulations.

The Pennsylvania delegation proposed an amendment calling on the Board of Trustees to investigate and evaluate the advisability, desirability, ethical and legal implications of exclusive contracts between physicians and hospitals, and to determine the impact of exclusive contracts on the quality and cost of medical care in the hospital setting.

The House voted to refer all matters on this issue to the Board of Trustees for study and to report findings and recommendations at the 1981 Interim Meeting.

The Ohio Delegation supported this action.

HEALTH PLANNING

The House adopted a report of the Council on Medical Service containing an AMA statement on Voluntary Health Planning and thirteen principles which should be considered in establishing a voluntary community health planning program. Among the principles adopted:

- Health planning should be the primary function of a collaborative group of community organizations and interested individuals.

Dr. Clarke, Gallipolis, is the Chairman of the Ohio Delegation to the AMA. Dr. Dunsker, Cincinnati, is President of the OSMA, and Co-Chairman of the Ohio Delegation.



Oscar Clarke, M.D., listens to discussion, prompted by his Resolutions Committee report.

Photo by Joe Fletcher, American Medical Association.

- The planning organization must be representative of the community, and have the active support and participation of the community to be served, including but not limited to physicians.
- The organization should exhibit thoroughness, objectivity, sensitivity to community interests, understanding of the health delivery system, and accountability to the community served.
- It should assume a positive role in assessing community health and medical care needs.
- It should serve an informational and educational role.
- The size and scope of the geographical area to be served should be determined by community residents.
- There should be a substantial commitment from the community to the support of the planning organization.
- Government may provide supplemental funding in support of local health planning activities.
- Local, voluntary health planning is a creative process, and therefore should not include the use of regulatory sanctions.

The Ohio Delegation supported the action of the House.

ELIMINATION OF FEDERAL SUBSIDIES FOR TOBACCO

The Ohio Delegation was in unanimous support of the House of Delegates in adopting a policy of supporting the elimination of federal price supports for tobacco. The House action further states that the policy of the AMA is that smoking is detrimental to health and that the AMA continue its educational programs to so inform the public.

HEALTH CARE OF THE AGED (GERIATRICS)

The Ohio Delegation was successful in amending a substitute resolution which now states that the AMA support the concept that the development of a formal practice specialty in geriatrics will be divisive and dilute the present efforts by a member of concerned specialties currently addressing the problems of the elderly. The policy adopted by the House and supported by the Ohio Delegation also directs the AMA to urge all appropriate specialties to emphasize further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels. Further, the AMA is to encourage all appropriate medical specialty certifying boards to assess pertinent knowledge regarding care of the aged in their certifying and recertifying procedures.

HEALTH MANPOWER

Several resolutions were considered by the House relating to a surplus of physicians or shortages by specialties.

The House voted to refer these resolutions to the Board of Trustees noting that an extensive report is to be made to the House at the 1981 Interim Meeting on current major manpower developments or issues related to physician population.

The Ohio Delegation supported referral.

JURISDICTIONAL DISPUTES

The House voted to refer to the Board of Trustees a reference committee's substitute resolution that resolved that it be AMA policy that individual character, training, competence, experience and judgment be the criteria for granting privileges in hospitals and that physicians representing several specialties can and should be permitted to perform the same procedures if they meet these criteria.

The Ohio Delegation supported referral.

ORGANIZATIONAL MATTERS

The House voted to:

- Discontinue the Council on Continuing Medical Education.
- Continue the Council on Long Range Planning and Development.
- Continue the Council on Constitution and Bylaws and to plan two meetings a year in conjunction with meetings of the House of Delegates.
- Preserve the Interim Meeting while authorizing the Board of Trustees to study a less costly gathering that would preserve participation in policy making.
- Approve a major restructuring of the AMA and staff.
- Raise dues $35 a year.
- Accept the principle of considering annual incremental dues increases in the next two years.
- Set dues for physicians in their second year of practice at 75% of regular AMA dues.
- Set dues for physicians in the military at two thirds the regular AMA dues, starting in 1983.
- Discontinue the Department of Negotiations and place the negotiations activities in the Office of General Council.

DRUG EFFICACY

The Ohio Delegation supported the House action in adopting a policy directing the AMA to urge acceleration in the FDA review of drugs deemed to lack "adequate evidence of effectiveness" and to involve practicing physicians in the review process.

FUNDING OF HMO'S

The House adopted the following policy regarding federal funding of health maintenance organizations:

> "Resolved, that the AMA continue to support the elimination of governmental funds for new start-ups of HMOs and the termination of funds for other HMOs after completion of the current governmental funding cycle."

The Ohio Delegation was in unanimous support of adoption of this policy.

CENTRAL DATA BANK ON HOSPITAL INJURIES

The House voted to refer to the Board of Trustees a resolution and the reference committee's recommendation on the use of central data processing for adverse patient outcomes in hospitals be accompanied by assurance of legal confidentiality.

The Ohio Delegation supported referral.

The Ohio Delegation was unanimous in supporting these actions.

There are many excellent reports presented to the House of Delegates at each meeting, covering a wide range of subjects that are of interest to physicians. These reports, prepared by AMA councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follows. If you would like a copy of any or all of these reports, please contact Jerry Campbell at the OSMA office.

1. **Environmental Analysis - The Economy, the Population, Legal Environment Regulation, Physician Manpower and Medical Technology**
2. **AMA Statement on Voluntary Health Planning (contains principles on Voluntary Health Planning)**
3. **Initiation of Voluntary, Locally Based Health Planning**
4. **Explanation of Medicare Benefits (EOMB) Form**
5. **Mainstreaming Medical Services to the Veteran**
6. **Health Insurance Legislation**
7. **The Essentials of Accredited Residency Programs in Graduate Medical Education**
8. **Examination for Medical Licensure**
9. **The Fifth Pathway**
10. **Required Evaluations for Physical Activities**
11. **Risks of Nuclear Energy and Low-Level Ionizing Radiation**
12. **Health Care Needs of an Underserved Population (Health Care Needs of Homosexuals)**
13. **Drug Abuse Related to Prescription Practices**
14. **Organ Donor Recruitment**
15. **Acupuncture**
16. **Electronic Fetal Monitoring**
17. **Report of the Executive Vice-President**
18. **The Cost of Medical Care: A Comparison Between Public and Private Settings**
19. **Appropriateness Review: The Rules of HSAs and PSROs**

Managing handicapped

ONE-DAY TRAINING PROGRAM to assist physicians in evaluating and providing medical management for handicapped children will be presented at Columbus Children's Hospital from 9 to 5 p.m., Wednesday, October 7, 1981. Sponsored by the American Academy of Pediatrics, the program's key instructor is Elizabeth Ruppert, M.D., of Toledo. OSMA's Joint Advisory Committee on Special Education is cooperating with the AAP - Ohio Chapter in this effort. Further details are available from the OSMA Department of Health Education.

BALDNESS:

The catastrophic event in my life

By Craig G. Burkhart, M.D.

Editor's note:

The information concerning health-related advertisements is factually correct. The author is however neither bald nor a world's authority on baldness per se. The author's interest in hair loss stemmed from writing a series of editorials on health-related advertisements for the* **Journal of Dermatology and Allergy for the Practicing Physician *of which he is the editor-in-chief. He has grown sensitive to the plight of the bald male, and it is for him that he writes this tale.*

The skeptical and somewhat negative attitude with which I approach any advertisement concerning a therapeutic agent for hair loss will suggest to some that I do not appreciate the importance of a youthful appearance, or possibly that I am calloused to those of us who are balding. Let me begin by acknowledging the importance of hair.

Hair is the symbol of virility. It is the visual sign of openness and strength in the male sex. It is the essence of esthetics in today's world. Unfortunately, in my case, sparsity of hair shafts on the scalp has led to a severe hair shortage. The loneliness in the heart is demonstrated so vividly on the head that embarrassment is uncontrollable. Beauty may be only



skin deep, but does baldness have to be so blatantly obvious? My scalp cries for aid or ornament, but as I am too vain to adorn a wig, I continue to hope for a "miracle cure" for my disability.

Through the years I have read numerous testimonials on hair advertisements in which young men, like myself, gain that youthful appearance within weeks of using a specific product. I have studied volumes of "before" and "after" pictures in which a transformation takes place on the scalp and dead hairs are rewakened with a magical tonic. But with each product, my appearance has not been rejuvenated. My hairs remain dead and hidden to the outside world.

I almost believe that baldness remedies are no better than all the other products I have tried for weight reduction, wrinkle removal, penis enlargement, impotency cures, and longevity formulas.

I have since investigated advertising in general and learned some unbelievable facts. First, the information in advertisements is not necessarily correct. Second the

"The loneliness in the heart is demonstrated so vividly on the head that embarrassment is uncontrollable. Beauty may be only skin deep, but does baldness have to be so blatantly obvious?"

advertisements in reputable magazines and newspapers are not necessarily screened by the publishers. The government, through the Food and Drug Administration (FDA) and Federal Trade Commission (FTC) does not license advertisements. Thus, some profit-motivated entrepreneur may publish an advertisement in a reputable newspaper or magazine claiming outrageous success for the party who uses their specific product.

I related this information to a lawyer friend (who is also bald), and he explained to me that advertising is a form of free speech. Thus, advertising is protected within the first amendment. On the other hand, Congress established the FTC to police all existing trade regulation laws and to prohibit unfair and deceptive practices. To make a long discussion short, the reading of the first amendment is modified slightly in reference to advertising in the interest of preventing deception.

My lawyer friend was quite patient with my numerous inquiries regarding the FTC and false advertising but he insisted I call the FTC myself if I had any more questions. Since I still had a few (in fact more than I had when I started), I proceeded to call the FTC in Washington, D.C.

My friend must not have realized how difficult it is to call anyone in Washington, D.C. I was transferred from department to department, from one secretary to the next. I finally reached someone whom I suspect was also bald, and who was willing to discuss this crucial topic with me.

My new acquaintance in the FTC related to me that the Commission has a most cumbersome and complex problem in enforcing its legislative power. Some of these problems include the fact that false advertising provides an enormous profit incentive in the health-related industry. Furthermore, because of minimal screening by the publishers, it is not difficult to advertise in all the various media and thereby attract many gullible consumers to buy their products.

At that juncture I immediately asked him if he thought I was gullible. I reassured him that I had closely read all testimonials, viewed all before and after photographs, and diligently read any small print in all advertisements before purchasing the items and products that I have accumulated for hair growth, weight reduction, etc. He hastily stated that he didn't think I was gullible, but added that he was late for a meeting and had to end our conversation. I would not allow him to hang up until he promised to send me additional information about the FTC and its policing efforts.



A week passed before I received the information and, from its numerous pages I gleaned the following: Any action of the FTC is, for the most part, *after* the fact, as the agency is unable to make any specific prophylactic rules. Although these profiteering companies may not be adhering directly to the wishes of the Better Business Bureau, until the FTC proves their advertising deceptive, they are not violating any specific regulations or laws. The sheer number of health-related advertisers does allow many health schemes to go unchecked because of the limited federal funds given to the FTC to perform its function. Moreover, if the FTC finds an advertisement with deceptive statements, no fine can be imposed by the Commission. Instead the incriminated company merely has to change or halt the questionable portion of the advertisement. In other words, the particular company is free to merely vary the original deceptive statements and a completely new investigation by the FTC would have to be initiated.

Just the other day I was rehashing the situation with my wife and she asked me what I wanted to do about it. I told her that just as plainly as she could see the skin on my scalp, I would like to do *something* to rectify the problem of deceptive advertising. One solution would be to educate the public to recognize what is right and what is incorrect in all health-related advertisements. However, given the vast amount of medical knowledge

that would be required, this solution is not very pragmatic. It would be impractical to believe that the advertisers themselves would police their own advertising — their livelihood depends on the deception in their ads. And certainly the publishers would find the screening of advertising time consuming, difficult and nonrewarding. After all, denying an advertiser space in their publication would mean loss of revenues.

My wife agreed with my reasoning so I proceeded to discuss with her the potential merit of the FTC as a policing agency. For example, the government could legislate authority to the FTC to levy civil monetary penalties against those profiteering companies which knowingly make fraudulent claims. Another alternative would be to require publishers to print disclaimers on all advertising for which the publisher is unable to vouch for the ad's veracity.

My wife suddenly became perturbed with me and said that I was becoming infatuated with hair loss and false advertising. Moreover, she staunchly requested that I see a psychiatrist for what she described as my growing neurosis.

I was completely taken aback by these comments because there is absolutely nothing wrong with me except that I am bald. But because of my wife's strong demand, I reluctantly went to see one of the psychiatrists at the hospital on an informal basis the following day.

At the hospital, I waited outside one of the large lecture halls in which the psychiatry department was meeting. Through a window in the door of the meeting room, I could see that not one of the full-time attending psychiatrists was bald. I knew right away that none of them could possibly understand the plight of a man losing his hair. There was, however, one of the younger residents who was balding and it was to him that I chose to relate my problem.

Upon seeing him leave the adjourned meeting, I immediately grabbed his arm and proceeded to relate my thoughts to him. I was surprised that he was not more aware of the mental anguish that accompanies the bald state of which he was soon to be a member. Furthermore, he felt uncomfortable discussing this problem with me and wished that I would see one of the older attending faculty on the psychiatry service. I told him I did not want to pursue the problem in that fashion.

He then suggested that I see the Chairman of the Department of Dermatology who had done extensive research in hair loss and was a world authority in this area. I responded by saying I was flattered by his compliments and pleased the psychiatry department thought so highly of my work. He was puzzled by my remarks until I introduced myself as Craig G. Burkhart, Head of Dermatology at the Medical College of Ohio. OSMA



Illustrations by Anna Borys

How do you manage anorectal barbed fire?

95% of colon/rectal surgeons surveyed* add TUCKS® pads concomitantly to preferred suppository/ ointment/cream medication for best results...

In Acute Hemorrhoidal Flare-u
Prescribe Anti-inflammato
Anusol-HC
suppositories/cream
with hydrocortisone acetate...
the #1 prescribed product**
for external and internal
hemorrhoids and other
common anorectal disorder

Plus

Soothing, cooling, comforting
Tucks®
The #1 premoistened hemorrhoidal pad* for added external relief and gentle cleansing of fecal residue that can irritate tender anorectal tissue.
Please see following page for full prescribing information.

PARKE-DAVIS
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Morris Plains, NJ 07950 USA
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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*. IMS America Ltd., September 1980.

PD-400-JA-0146-P-1

TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads
Hemorrhoids and other anorectal uses–TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witchhazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.
Vaginal Uses–Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
1089G010

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How to enjoy retirement

Retirement does not have to lead to inactivity, loss of self-esteem and deteriorating health, says Valery A. Portnoi, M.D., in a recent issue of the *Journal of the American Medical Association*.

In fact, Dr. Portnoi claims, retirement may have a more positive influence than people commonly believe.

The answer may lie in preparing for retirement early, even as early as ten years before. Preparation should include estimating the changes in income and expenditure that will occur; learning the principles of health and nutrition that apply to older people; beginning a program of physical fitness that can be continued through retirement; and investigating new intellectual pursuits.

Equally important, Dr. Portnoi stresses, are social activities, because they enhance enthusiasm about life.

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An O-M-E-N of things to come

After years of double digit inflation and triple digit gasoline costs, increasing numbers of physicians are beginning to reexamine the available alternatives in continuing medical education. While CME conferences and meetings have their place in the postgraduate education picture, many cost-conscious doctors have begun to recognize that 1981 is not the time for "business as usual."

One of the "new" CME approaches is the Ohio Medical Education Network (OMEN), which makes use of amplified telephones attached to loudspeakers and amplifiers to bring current medical insights to physicians from Michigan to Florida, from New York to Saskatchewan, Canada. The OMEN "communications system" is tied together with slides that are delivered to each hospital before each lunch hour program. It permits a 30-minute slide/lecture presentation to be followed by a "live" two-way interactive discussion period in which practicing physicians in diverse regions of North America engage in dialogues with one another and with medical faculty from five medical schools. The hour-long OMEN programs take up a minimum amount of time from the physicians' tight schedules, while keeping them current on medical advances and meeting their needs for Category 1 credit. Thirty credits are earned through attendance at the 30 once-a-week programs, which are held from mid-September through April.

With medical staffs at 145 hospitals in 14 states and two Canadian provinces taking part in the network in 1981, about 2,000 physicians a week benefit from the OMEN programs.

This constitutes the largest such physician's interactive network in North America, and, with OMEN having been founded in 1962, that also makes the Ohio Medical Education Network the oldest two-way physician's network in continuous operation.

Although hospitals in such major cities as Chicago, Detroit, Atlanta, Cleveland, and Cincinnati participate in OMEN, the network is especially attractive to hospitals in the rural areas. Picture the physician in the small town 50 miles from a major city. He loses two or three hours just going to and from a medical conference. Depending upon the conference length, he may have to spend a day or more away from his patients or his local hospital. With OMEN at the local hospital, he simply goes to the hospital and has lunch, while watching the program. He then can talk back and forth with a medical faculty member presenting the program, listen to questions posed by other doctors in another state, and even get "closed circuit" consultation on a patient he has. He is very much in touch with a variety of medical thinking on a variety of diseases, without even leaving the city limits of Ashtabula, Ohio or Welch, West Virginia or Marion, Illinois. At the end of 30 weeks, he has earned 30 credits of Category 1 without making any expensive or time-consuming trips out of town. Individuals wishing more complete information about OMEN are invited to call the Networks Coordinator at 614/422-4985 or write:

Arthur A. Bartfay
Networks Coordinator
OSU CCME
A-352 SL 320 W. 10th Ave.
Columbus, Ohio 43210

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Continue therapy with Anusol® Suppositories/Ointment to help maintain relief of hemorrhoidal or other anorectal symptoms
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NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.
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Effective • Economical • Convenient • Recommendable

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

Congressman Luken and the FTC

By A. Burton Payne, M.D.



Thomas A. Luken is taking on the FTC . . . again.

The Federal Trade Commission has already tried to throw its weight around behind state lines. But one Ohio Congressman refuses to budge another inch.

Dr. Payne, Ironton, is Chairman of the OSMA Legislation Committee

The power of the Federal Trade Commission (FTC) to become involved in the activities of state-regulated professions, including medicine, could be severely limited if recently introduced legislation is enacted.

Congressman Thomas A. Luken (D-Cincinnati), introduced legislation that places a moratorium on FTC actions against state-regulated professions. Congressman Luken told the House, "One of the most questionable and controversial areas of expansion by the FTC in recent years has been its involvement in activities of the state-regulated professions. Even though it has never been given express authority by Congress to do so, the FTC has increasingly sought to usurp state responsibility, override state laws and preempt state regulation."

He added that, "Congress most certainly has a duty to define the parameters of FTC authority with respect to state-regulated professions but absent the specific granting of any such authority, Congress has a corresponding duty to allow the state and professions involved to exist without continued interference."

This is not the first time Congressman Luken has taken on the FTC. Last year, he was involved in a House attempt to limit the activities of the FTC in conjunction with a Senate floor vote known to physicians as the McClure-Melcher amendment. That Senate vote, and Congressman Luken's continued activities, clearly demonstrate a substantial degree of interest in, and concern over, the FTC and its activities. Congressman Luken said he hopes the bill also will serve as

a vehicle for the House to address the issue of FTC authority in general.

"We have the obligation and responsibility to resolve such fundamental questions of state-federal jurisdiction, particularly when there has been such a sweeping assertion of federal dominance without any real authority to justify it," he told Congress.

"Congress has a duty to allow the state and professions involved to exist without continued interference"

The OSMA House of Delegates voted endorsement of this legislation at its recent Annual Meeting (Resolution 61-81) and sponsored a resolution before the AMA House of Delegates urging AMA support of House Rule 3722. It was adopted unanimously.

Please encourage your Representative to join Congressman Luken in this fight against the unauthorized and excessive activities of the FTC. Without strong support from Ohio, the legislation faces a tough route in the House of Representatives.

Once again, the role of the individual physician with his or her congressional representative will be a key factor in the ultimate success — or loss — of this important and necessary legislation. Letters to your Representative expressing your hope that he or she will cosponsor and support HR 3722 should be addressed in care of the House Office Building, Washington, D.C., 20515.

Environment study

A national conference on environmental toxicants and human health will be held September 14-16 in Arlington, Virginia.

Conference participants will explore better ways to safely transport potentially hazardous substances, in addition to other matters pertaining to environmental health.

The AMA says . . .

A bill to place a moratorium on activity of the Federal Trade Commission with respect to certain professions and professional associations until the Congress expressly authorizes such activity.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, **That (a) the Federal Trade Commission shall not investigate, issue any order concerning, prescribe any rule or regulation with respect to, or take any other action against any State regulated profession until the Congress takes the actions specified in subsection (b).**

(b)The prohibition established in subsection (a) shall apply until the Congress enacts legislation which expressly provides that—

(1)the Commission has jurisdictional authority with respect to professions; and

(2) the authority of the Commission preempts the authority of States to regulate professions.

Sec. 2. Any decision, finding, or other administrative action made or taken by the Commission which—

(1) occurs during the period beginning on May 28, 1981, and ending on the date of enactment of this Act; and

(2) is based in whole or in part on any activity specified in subsection (a) of the first section of this Act; shall, upon the enactment of this Act, be vacated and have no force or effect.

Whereas, Medicine and other professions have a long tradition of self-regulation in the public interest; and

Whereas, The states have historically complemented this self-regulation with highly satisfactory, adequate, and effective licensing, monitoring, and enforcement activities; and

Whereas, Notwithstanding that record of responsible and successful combined regulation at the state level, the Federal Trade Commission has, without authority from Congress, increasingly interfered with professional activities and preempted state laws relative to the professions; and

Whereas, Ohio's Second District representative, Tom Luken, has introduced legislation to place a moratorium on activities of the Federal Trade Commission with respect to certain professions and professional associations; a moratorium which would stop this interference by the FTC; therefore be it

RESOLVED, That the American Medical Association support HR 3722, a bill limiting the Federal Trade Commission's activities toward professionals.



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Most doctors remember the medical professional liability insurance crisis of the mid-seventies. Companies refused to accept new business, withdrew from the market completely, or demanded huge surcharges. That's when and why Pico was formed.

Pico's rapid success brought about dramatic improvements. Today, doctors have several sources for professional liability insurance. We're pleased, because healthy competition helps everyone.

We hope that doctors always will have several alternatives for professional liability insurance protection. We know that doctors always will have Pico. If another crisis occurs . . . and the experts say there will be one, and soon . . . Pico will be in business to serve all of the members of the Ohio State Medical Association.

That's the commitment we made in 1976. And that is one aspect of the medical professional liability insurance market that has not changed.



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Phone (614) 864-7100 or
1-800-282-7515.

After a fashion

By Gina DiBlasio Cummins

While his nine-year-old peers were absorbed in the typical hobbies such as gluing model airplanes, practicing for the little league, and capturing lightning bugs, Russell Trusso, D.O., a Cleveland neuroanesthesiologist, was busy designing his first article of clothing, and at 12 years old had already hand-painted his first garment.

"I definitely would have received more pats on the head if I had been cutting up frogs," says Dr. Trusso. "People didn't condone what I was doing." Undaunted, however, Dr. Trusso has nurtured his fascination with fashion from a mere hobby to what has become a significant business in fashion design.

"Why would an already highly successful physician wish to pursue what has become a second career? 'I have always dreamed about being a designer, and decided to go ahead and live out my fantasy!' "

Why would an already highly successful physician wish to pursue what has become a second career? "I have always dreamed about being a designer and decided to go ahead and live out my fantasy!" Once he made up his mind, Dr. Trusso bought himself a sewing machine and began to sew. His first "masterpiece" emerged from the machine without a zipper — but his wife somehow found a way into it, and bravely wore it through a dinner party. Despite the "difficult fit" it was enthusiastically received, and Dr. Trusso's "fantasy" finally took it's first teetering steps toward reality.

"My designs are for women who want to look beautiful," says Dr. Trusso. "There is no reason why a female lawyer has to wear a pinstripe suit — she has so many more softer, flattering options." Dr. Trusso views fashion as an art form and loves to create pretty, romantic clothing that consists of a "little bit of fantasy" but which is still ruthlessly practical. How can fashions designed of the lace, moire, velvet, satin, and silks that mark his collections, be deemed practical? "Practical in the sense that they are classic designs which are made well, and can be worn over and over. They're also versatile and travel well," he explains. Women can be practical but still dress to be show-stoppers, says Trusso — a belief which motivates his creation of original designs. "I don't like to be influenced by what other designers are showing. I want to achieve a certain look that sets me apart from the others." He feels that each designer should specialize in what he or she does best — in his case that's hand-painting truly stunning garments. "But it's not as easy as it sounds," says Dr. Trusso. "Before I design or hand-paint a collection, I sit down and do my homework — which includes pouring over tons of women's fashion magazines and studying the current market closely to find out what women want."

Doing his homework has paid off — Dr. Trusso's fashions now can be found in several major stores in the Cleveland area, and soon in major department stores in the Columbus, Cincinnati, and even Washington, D.C. areas. Unlike other designers, Trusso is quite content to design for the midwest market. "The midwest is underestimated — women in this area want to look pretty too," he notes, adding, "Since my designs are unique, my goal is to capture the attention of women in this area who are making special trips to New York City to find

Gina DiBlasio Cummins is a staff writer for the Ohio State Medical Journal.



Dr. Trusso's preliminary sketches are translated into fabric by highly skilled and conscientious seamstresses.

outstanding fashions."

If a shopping spree to New York is inconvenient and you don't like to buy off the racks, Dr. Trusso can accommodate your custom order within two weeks.

"I realize that women don't want to wait weeks or months for a special garment, and they shouldn't have to. When a client comes to me with a custom order, I sit down with her personally and we discuss what she has in mind. I usually question them so extensively about the way they want to look, that in a sense they create their own design." Dr. Trusso also designs many one-of-a-kind fashions, and although he strives to please his clients, he emphasizes that he does not sell a client a design which he feels will not be flattering.

"Buy clothing that you like, but be sure that it looks good on you — don't succumb to trendy fashions," warns Dr. Trusso. He adds that you cannot buy good taste.

"Some people have that certain flair. They are able to coordinate clothing and accessories naturally — and consequently, they achieve a classic timeless look without exorbitant spending. Usually, women who look

The AMA-ERF fashion show



Dr. Trusso (background) presented a fashion show of his designs to benefit the OSMA's Auxiliary AMA-ERF fund.

It could have been Paris in the spring . . . haute couture on the Left Bank.

Members of the Ohio State Medical Association Auxiliary and their guests lost track of time and place as they listened to Russell Trusso, D.O., a Cleveland neuroanesthesiologist and fledging dress designer describe his latest collection of dresses at a fashion show, presented during this year's Annual Meeting.

Proceeds from ticket sales went toward the AMA-ERF fund, some $310 in all.

"It was a successful fund-raiser," said Sarah Sato, the Auxiliary's immediate past president, "and it was easy to do. All the dresses were beautiful and exquisitely detailed."

Move over, Yves St. Laurent. You've got company in Cleveland.

— Karen S. Edwards

good really like themselves. If you like who you are, it shows, and a certain inner glow enhances anything you wear."

Dr. Trusso believes that fashion is headed toward a more individualized style. "Women now have a choice and can achieve whatever look they desire. The romantic look is making a comeback," he predicts, "and with the return to moire fabric and lace, we'll see a return to the elegance of the old days as well."

Unfortunately, the fashion scene looks bleaker for men. "Frankly, most men are terrible dressers," admits Dr. Trusso, "but we are not privy to the luxurious fabrics that women are. Many men are secretly interested in fashion, but at the same time feel intimidated by it."

"Frankly, most men are terrible dressers, but we are not privy to the luxurious fabrics that women are."

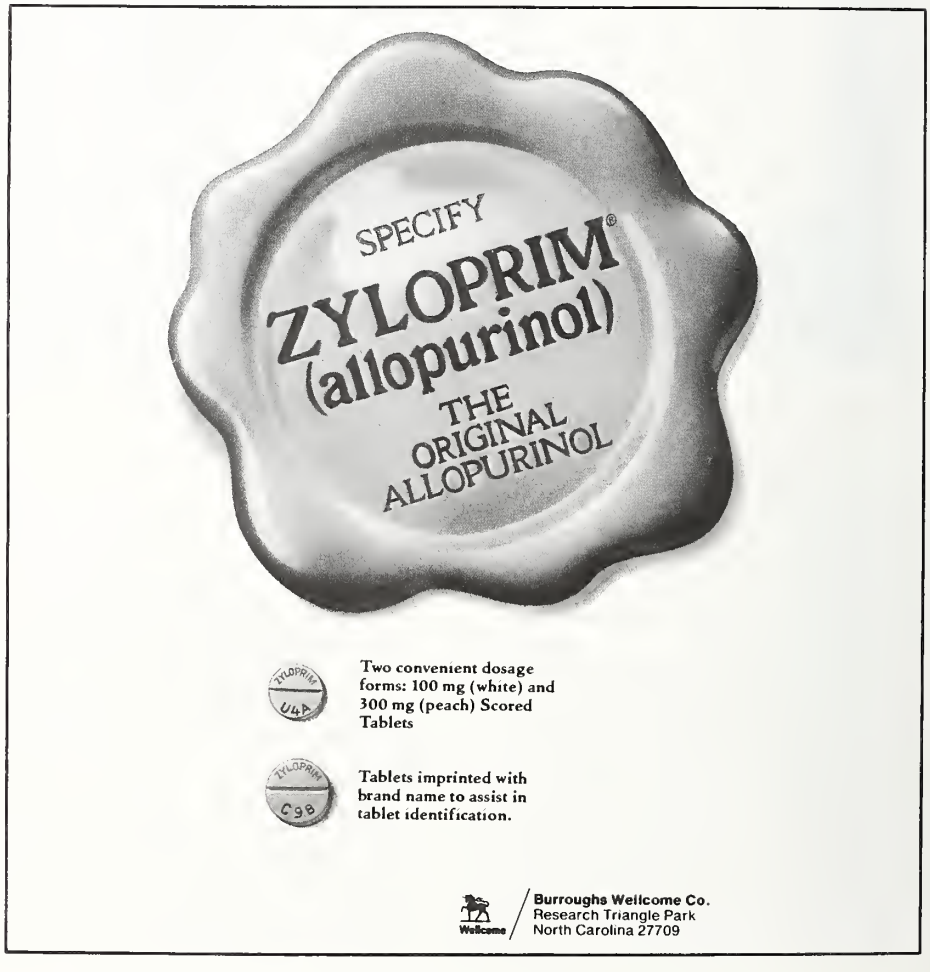
Raised in a supportive environment — his father designed special lace-making machines for Vanity Fair, and his mother was a professional model — Dr. Trusso did not experience the intimidation someone experimenting in the world of fashion and design might ordinarily feel. "When I finally decided to embark in this field in a professional capacity, my close friend Sally was at my side to bolster my confidence. She is a terrific business partner and we work as a team." In fact, Sally models many of his designs and proffers advice with each new creation. "If she doesn't like a design which I have deemed a masterpiece, she simply won't wear it. It shatters my ego, but I rely on her good judgment — in hindsight, she's usually right."

The chemistry must work — the creative mind balanced by good judgment — because Dr. Trusso's fashions will soon be popping up on clothing racks all around the state, and perhaps soon, around the country. When this Cleveland neuroanesthesiologist leaves the hospital clinic after a long day, he leaves it "for good," — but, as it turns out, for the good of fashion-conscientious people everywhere.





Left: Dr. Trusso discusses the details of his design before an attentive Auxiliary audience. Right: The model provides Auxiliary members with a closer look.



CONTINUING EDUCATION PROGRAMS

September

SYMPOSIUM ON THE PSYCHOBIOLOGY OF HEALING: September 21; Marriott Inn, Columbus; sponsor: Harding Hospital, Worthington; 6.5 credit hours; fee: $40; contact: Registrar, Harding Hospital, 445 E. Granville Road, Worthington 43085, phone: 614/885-5381.

EAR, NOSE AND THROAT SYMPOSIUM FOR PRIMARY CARE PHYSICIANS: October 9; Kresge Auditorium, University of Cincinnati College of Medicine; sponsor: University of Cincinnati Medical Center; 8 credit hours; fee: $50; contact: J. Oliver Donegan, M.D., Dept. of Otolaryngology, University of Cincinnati Medical Center, 231 Bethesda Ave., Cincinnati 45267, phone: 513/872-4153.

October

DERMATOPATHOLOGY SELF-ASSESSMENT WORKSHOP: October 11; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: $75, $40 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

NUTRITION, IMMUNOLOGY AND CANCER: October 12-13; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $120, $60 for students or physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation; 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

UPDATE ON RHEUMATIC DISEASE: October 14-15; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $120, $60 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

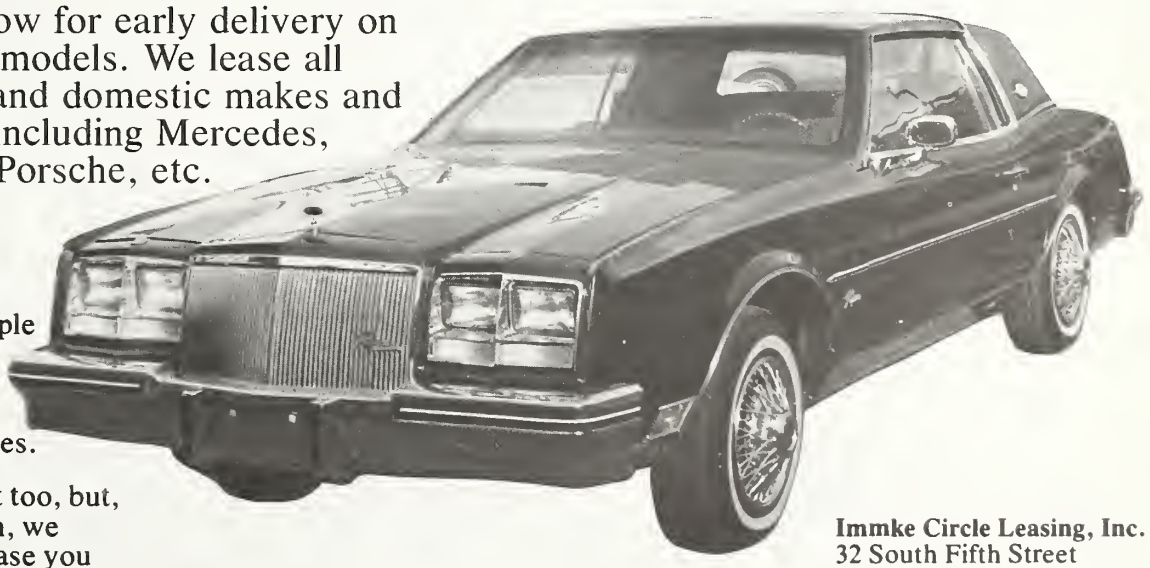
SYMPOSIUM ON VOCAL AND LARYNGEAL DISORDERS: October 16-17; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $120, $60 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

THE CARE AND SUPPORT OF THE CANCER PATIENT: October 31; Youngstown State University - Schwebel Auditorium; sponsor: Mahoning Shenango Area Health Education Network; 6 credit hours; fee: $15, $8 for students and residents; contact: Richard W. Juvancic, M.D., Coordinator of Medical Education, Youngstown Hospital Association, 345 Oak Hill Ave., Youngstown 44501, phone: 216/747-0751.

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"Laughing gas" successful pediatric sedative

"Laughing gas" has been found to be an effective tranquilizer for children who face painful treatment in the physician's office, says a report in a recent edition of the *Journal of the American Medical Association*.

Glen C. Griffin, M.D., University of Utah College of Medicine, Salt Lake City, reports on use of a mixture of nitrous oxide (laughing gas) and oxygen to sedate some 3,000 children in preparation of sewing cuts, removing fishhooks and splinters and various other painful procedures.

Fear and apprehension were decreased, resulting in happier children, parents and medical personnel, says Dr. Griffin. There were virtually no untoward side effects. The nitrous oxide-oxygen mixture was not a substitute for the injection of local anesthesia for suturing, but calmed the children so that the fear of the pain of the needle was greatly reduced, he says.

Obituaries

CLARENCE ADAMS, M.D., Galion; Ohio State University College of Medicine, 1921; age 87; died May 9, 1981; member OSMA and AMA.

RALPH J. BEARE, M.D., North Reddington Beach, Florida; St. Louis University School of Medicine, 1931; age 75; died May 5, 1981; member OSMA and AMA.

CHARLES HATFIELD, M.D., Columbus; Ohio State University College of Medicine, 1945; age 61; died May 14, 1981; member OSMA and AMA.

RAYMOND W. MARTZ, M.D., Hamilton; University of Cincinnati College of Medicine, 1941; age 65; died May 19, 1981; member OSMA and AMA.

JAMES W. McCUBBIN, M.D., Shaker Heights; Harvard Medical School, Boston, 1946; age 60; died May 14, 1981; member OSMA.

ASA E. SEEDS, M.D., Cincinnati; Stanford University School of Medicine, Palo Alto, California, 1958; age 47; died May 19, 1981; member OSMA.

GERALD S. SHIBLEY, M.D., Highstown, New Jersey; Columbia University College of Physicians and Surgeons, 1916; age 91; died May 13, 1981; member OSMA and AMA.

LADISLAUS STERNICKI, M.D., Cleveland; Case Western Reserve University School of Medicine, 1918; age 90; died May 18, 1981; member OSMA and AMA.

HAROLD STURGEON, M.D., South Point; Kansas City College of Osteopathy-Surgery, 1958; age 54; died April 14, 1981; member OSMA.

THOMAS F. ULRICH, M.D., Barberton; Loyola University Stritch School of Medicine, Maywood, 1948; age 62; died May 16, 1981; member OSMA and AMA.

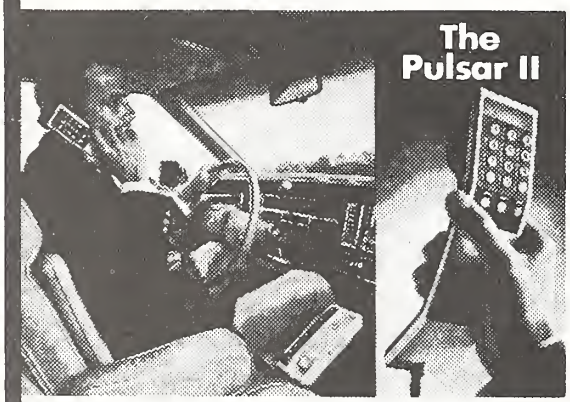
JOHN E. WALLACE, M.D., Wadsworth; Case Western Reserve University School of Medicine, 1952; age 54; died May 14, 1981; member OSMA and AMA.

ABRAHAM WIGSER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1927; age 80; died December, 1979; member OSMA and AMA.

Former AMA Rural Health Chairman dies

ROBERT E. REIHELD, M.D., Orrville; Ohio State University College of Medicine, 1941; age 65; died June 20; member OSMA and AMA. Dr. Reiheld served as chairman of the OSMA Committee on Rural Health for many years and was chairman of the Council of Rural Health for the American Medical Association. He served as team physician for Orrville High School for 35 years and was a founder and member of the Seven County Health Planning Commission in Northeast Ohio.

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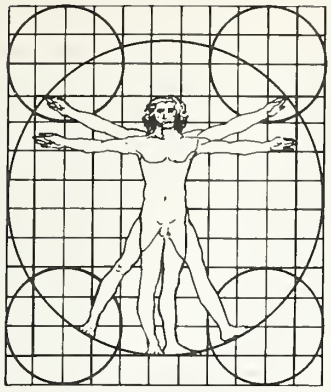
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CLINICAL & SCIENTIFIC

A HIGHLY SUCCESSFUL APPROACH TO OPERABLE PROSTATE CANCER IN A COMMUNITY HOSPITAL

Nicholas R. Spagnola, M.D.
William T. Paul, M.D.
J. P. Smith, M.D.
Mark Saylor, M.D.

In the past 30 years at Mt. Carmel Medical Center, Columbus, Ohio, stage B prostate cancer has been treated in a highly successful manner using a radical perineal surgical approach. Radiation and estrogen manipulation were used in selected patients as necessary for palliative measures. The survival rates of our group of 60 patients over a 15-year period approached a comparable age group of the general population. It is clear that although few operable cases of prostate cancer are found by each physician, a potential cure is possible in each case.

CANCER OF THE PROSTATE is the second most common malignancy in American men and the third most common cause of cancer deaths in men over the age of 55.[1] Its incidence is as frequent as 40% to 50% in men over 70.[2]

Etiologically, prostate cancer has not been shown to have a relationship with benign prostatic hypertrophy.[3] It is rare in Orientals[1] and most prevalent in blacks.[4]

An environmental etiology is suspected, as the incidence in Orientals increases as they migrate to the United States, yet never to the American level.[5]

Prostate cancer traditionally but erroneously has been characterized as indolent, slow growing, and not warranting vigorous treatment. It is the purpose of this article to show that this common cancer is readily treatable in a community hospital with minimal morbidity and a very high success rate when detected before distant metastasis occurs.

We encourage large-scale screening by routine rectal examination even though only 5% to 10% of the prostate cancers found this way will be in the surgically treatable, localized stage B category.

Staging and Treatment

Stage A prostate cancer clinically reveals no induration on digital rectal examination. Microscopically, it is confined within the gland itself. Focal disease (stage A_1) cancer requires no therapy other than transurethral resection of the prostate. If histologically the disease is diffuse throughout the gland, megavolt radiation is recommended following transurethral resection,[6] although this is controversial. Some authors recommend no further treatment but only observation and reevaluation as in stage A_1.

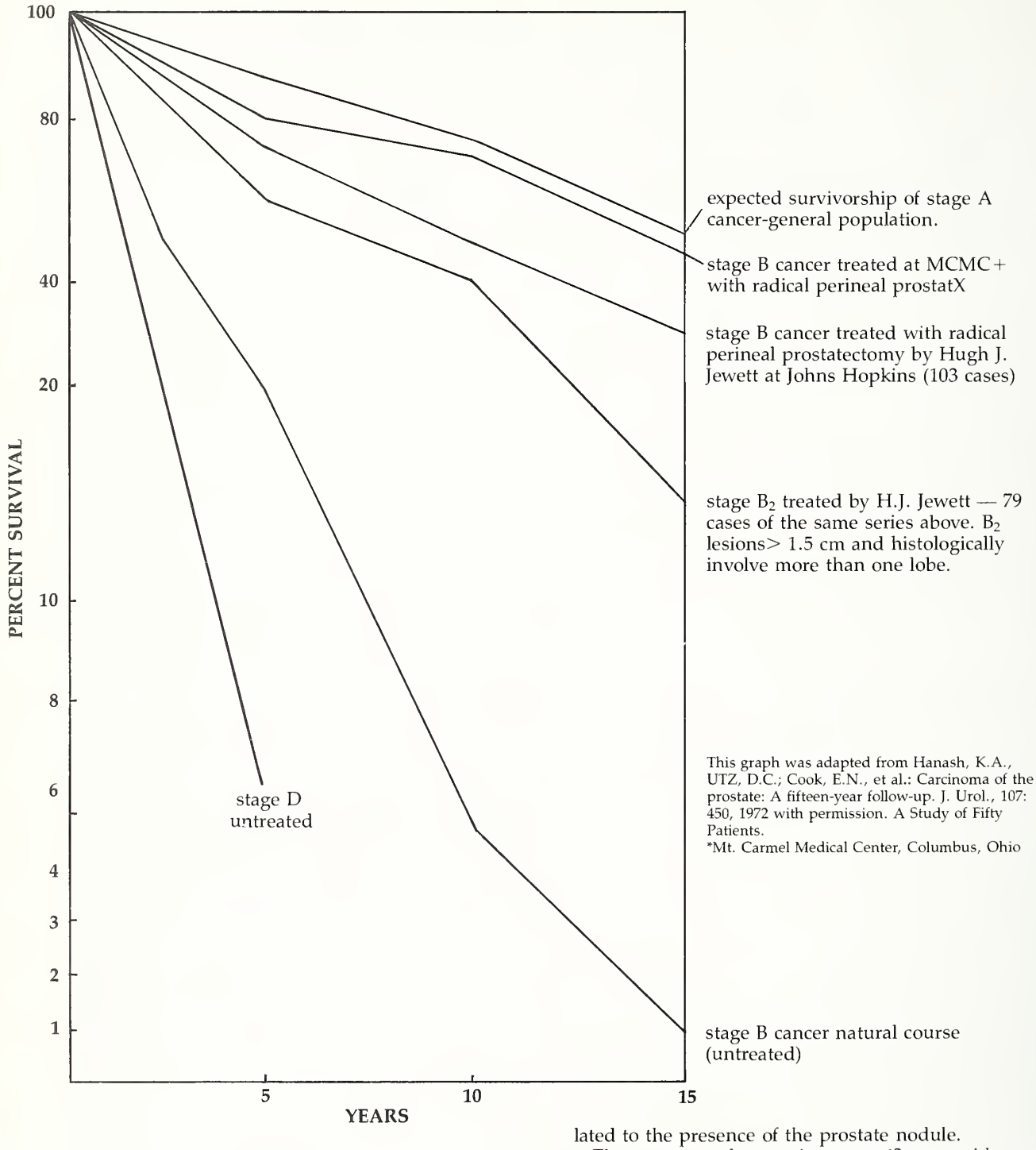
Stage B disease is detected by digital rectal examination as a gland that is firm or indurated in any particular area. Histologically, it also is confined within the gland. Radical prostatectomy should be reserved ideally for stage B disease as it gives the best 15-year survival and is quicker, less expensive, and has fewer side effects[7] than other therapeutic modalities.

Stage C cancer is disease that either clinically or pathologically shows extraprostatic extension, ie, outside the capsule. Traditionally no radical surgical treatment is recommended.[8] Radiation therapy provides good local control 85% to 90% of the time but its efficacy is marred in most cases by metastasis.[9,10] One reason for this could be understaging because approximately 50% of stage C cancer is in actuality stage D cancer.[10] Endocrinologic therapy has no effect as far as increasing survival[12] and even has increased the risk of cardiovascular deaths when more than 1-milligram and 5-milligram doses of diethylstilbestrol per day have been used.[5]

Stage D prostate cancer involves metastatic disease to regional or distant lymph nodes or other organs such as viscera or bone. Endocrinologic manipulation has offered no survival advantages[13] to patients treated early and is recommended only after symptoms begin,[11] but does make life more tolerable.

Dr. Spagnola, Columbus, Senior Family Practice Resident, Mt. Carmel Family Practice Program.
Dr. Paul, Columbus, Director, Mt. Carmel Family Practice Program.
Dr. Smith, Columbus, Senior Attending Urologist, Mt. Carmel Medical Center.
Dr. Saylor, Columbus, Senior Attending Urologist, Mt. Carmel Medical Center.
Submitted April 21, 1980.

SURVIVAL OF PATIENTS WITH PROSTATE CANCER BY STAGE



This graph was adapted from Hanash, K.A., UTZ, D.C.; Cook, E.N., et al.: Carcinoma of the prostate: A fifteen-year follow-up. J. Urol., 107: 450, 1972 with permission. A Study of Fifty Patients.
*Mt. Carmel Medical Center, Columbus, Ohio

Our Study

This is a study of 60 cases of prostate nodules discovered from 1949 to 1980, all presumed clinically to be stage B cancer and evaluated at Mt. Carmel Medical Center. The cases were obtained from the records of three local urologists and comprise all the cases they had felt were stage B disease on the basis of clinical criteria over the indicated 30-year span.

Of this series, 20% were discovered by routine rectal examinations and were asymptomatic. Of those patients who were symptomatic, 44% had nocturia, 26% hesitancy, and 13% dysuria, with many having multiple symptoms including a few not mentioned here. These symptoms were probably unrelated to the presence of the prostate nodule.

The mean age of our patients was 62 years with a range of 45 to 79 years. Ninety-four percent were beyond the fifth decade of life.

Nearly all 60 patients had undergone extensive workups including routine labs: SMA-12, alkaline phosphatase, acid phosphatase, IVP, CXR, EKG, pelvic roentgenograms, and biopsy of the lesions before surgery. Fourteen patients had bone scans as a preoperative test in the last six years. None of our patients had regional lymph node dissections or lymphangiograms prior to surgery.

All 60 patients underwent radical prostatectomy. Fifty-seven were found to have pathologic evidence of adenocarcinoma of the prostate on frozen section. In three cases no path-

CASES STUDIED

Patient	Age	Date first seen	Date surgery	Estrogen Rx?	Pathology report	Other Rx	Survival as of 3/80
E.S.	56	2/62	10/62	+	Grade I	0	alive—no disease
S.D.	59	10/56	3/57	+	Grade III	0	expired 8/59—metas.
H.D.	52	1/59	7/73	+	Grade III	0	expired 8/73—MI
H.F.	59	3/56	4/56	+	Grade III	0	lost to follow-up
H.F.	66	2/56	4/56	+	Grade II stage C	0	expired 3/63—metas.
A.H.	72	?	4/52	−	Grade III	0	expired 7/52—metas.
D.H.	59	7/68	10/68	−	AdenoCA*	0	alive and well
F.H.	76	10/60	11/60	+	Grade I	0	expired 1/67—MI
M.J.	64	8/63	9/63	−	AdenoCA*	0	expired 2/77—? etiol.
P.H.	61	9/73	10/73	−	Grade II	0	alive—no disease
C.A.	63	6/61	7/61	−	AdenoCA*	0	expired 5/70—lung CA
F.B.	63	5/51	5/51	−	BPH	0	(deleted from study)
E.B.	64	?	4/62	−	Grade I	0	alive and well
D.B.	64	10/63	2/64	−	AdenoCA	0	alive and well
G.C.	54	5/64	5/64	+	Grade III	orchiX	expired 12/69—metas.
J.L.	61	8/62	11/62	+	Grade III	0	expired 12/79—? etiol.
G.L.	61	2/75	5/75	+	Grade II	0	alive and well
S.L.	59	6/58	10/58	+	BPH, infarct	0	(deleted from study)
T.L.	74	5/50	5/50	−	Grade III	0	expired 1965—MI
H.M.	57	1/74	2/74	−	Grade III	0	expired 6/76—metas.
J.R.	66	3/66	10/67	+	Grade III	orchiX	alive and well
H.T.	66	9/62	10/62	+	Grade III	0	alive and well
F.S.	72	3/55	7/55	+	AdenoCA	0	expired 1965—CVA—no CA
W.W.	61	3/74	5/74	+	Grade III	0	alive and well
J.S.	75	11/67	11/67	+	Grade III	0	alive and well
W.S.	62	9/49	1/50	−	Granulomatous prostatitis	0	(deleted from study)
C.G.	53	9/74	11/74	+	AdenoCa stage C	0	expired 12/78—metas.
R.G.	68	5/67	11/67	+	Grade III	0	alive and well
R.H.	63	1/53	6/53	+	Grade III	0	alive and well
C.H.	79	5/51	5/51	−	Grade II	0	expired—metas. 1953
W.H.	47	8/63	8/63	−	Grade I	0	alive and well
V.D.	57	1/73	2/73	+	Grade I	radioRx and orchiX	expired 9/78—metas.
T.P.	52	6/69	1/75	+	Grade III	RadioRx and orchiX	living with metastases
E.P.	62	10/66	11/66	−	Grade II	0	alive and well
J.R.	65	12/69	2/70	−	Grade II	0	alive and well
J.S.	56	9/63	10/63	−	Grade I	0	alive and well
H.F.	61	3/57	4/57	−	Grade III	0	expired 7/64—metas.
P.F.	61	3/78	5/78	−	Grade I stage C	0	alive without metastases
D.G.	57	4/67	4/67	−	Grade I	0	alive and well
G.G.	57	8/59	10/59	+	Grade I	0	alive and well
B.G.	68	3/73	4/73	+ prior to surgery	benign	0	(deleted from study)
S.P.	59	12/63	12/63	−	adenoCA	0	expired—CA lung
G.P.	45	11/62	11/62	−	adenoCA	0	alive and well
H.R.	58	6/74	9/74	−	adenoCA stage C	0	alive and well
E.T.	71	2/72	3/72	+	Grade I	0	alive and well
W.Z.	65	10/70	11/70	−	Grade I	0	alive and well
E.M.	62	6/64	6/64	−	Grade III	−	Died 10/72—MI
W.M.	69	7/78	4/79	−	Grade III stage C	radioRx	alive and well
H.M.	56	2/72	4/72	−	Grade I stage C	radioRx and orchiX	alive and well
S.M.	61	3/52	5/52	−	granulomatous prostatitis	−	(deleted from study)
H.O.	61	9/57	1/58	−	Grade II	−	lost to follow-up
V.T.	49	3/64	4/64	−	AdenoCA	−	alive and well
D.D.	65	2/72	6/72	+	Grade I stage C	−	alive and well
M.J.	64	6/63	9/63	+	Grade III	−	expired 2/77—? etiology
T.P.	65	1/67	2/67	−	Grade III stage C	−	expired 7/75—metastases
D.P.	52	6/61	10/66	−	Grade I	−	alive and well
H.K.	67	10/72	11/72	+	Grade II stage C	−	alive and well
J.S.	53	12/63	1/64	−	Grade I	−	alive and well
R.S.	64	2/63	5/63	−	Grade III	−	expired 9/71—? etiology
W.O.	53	2/52	3/78	−	Grade I	−	alive and well
A.R.	62	11/63	11/63	−	AdenoCA	−	alive and well

**On the final Pathology report no typewritten record could be found as far as the staging and grade of the tumor.*

ologic evidence was recorded on frozen section, however, total excisional biopsy was performed. Two of these patients had granulomatous prostatitis and the third had a prostatic infarct.

Final pathology reports after radical surgery revealed two additional cases of benign disease (benign prostatic hypertrophy). Among the remaining 55 cases, 45 were stage B and ten (20%) were already stage C disease, ie, spread locally beyond the capsule, determined from surgical pathology specimens. This 20% figure is in accord with statistics from Jewett's 1972 study.

Palliative treatment was given to 25 patients treated with diethylstilbestrol in low doses (less than 6 mg per day). Nineteen of the 26 were given DES within one to three years following surgery, usually because of indurated areas detected on follow-up rectal examinations or secondary to bone pain. Six of the 25 patients given estrogens received them preoperatively, expecting that some shrinkage of the nodule and gland itself would occur, which it did. Finally, one patient received preoperative and postoperative DES.

Four patients also were treated with local radiation and five with orchiectomy. Only one patient to date has died from cardiovascular causes after hormonal manipulation.

The average survival in the postoperative period to date is 13.3 years. The average 5-, 10-, and 15-year survival is 80.5%, 65%, and 46%, respectively.

Postoperative mortality included only one case of fatal myocardial infarction four days postop. Postop morbidity included greater than 90% impotence, severe incontinence requiring use of a Texas catheter in 4%, and temporary stress incontinence of a lesser degree in less than 10%. All urinary tract infections were controlled with antibacterials without significant morbidity.

Twenty-one patients have died so far in the group of 55 mentioned above. Of this group only ten died of prostate cancer. The remainder died of cardiovascular-related deaths and two of primary lung cancer. Only two patients were lost to follow-up in our study, one at two years and the other at six years.

In summary, only 18% of all patients in the study have died of prostate cancer to date. All but one patient that died of prostate cancer had moderately to poorly differentiated adenocarcinoma.

The projected natural survival rate of untreated stage B prostate cancer is 20% and 5% at five and ten years, respectively. The operated Mt. Carmel survival rate is well above the projected natural stage B survival rates and moderately better than the national averages in the surgically treated stage B cancer (see figure).

Conclusion

The results of radical prostatectomy for stage B prostate cancer at Mt. Carmel Medical Center have been reviewed and compared to the national literature. The results of radical surgical treatment of early prostate cancer are somewhat better than the national average with a five-year survival of 80.5%, ten-year survival of 65%, and 46% fifteen-year overall survival. Review of our graph reveals nearly identical survival figures of our patients compared to the expected survival of a comparable age group of the general population, ie, essentially a surgical cure.

It should be mentioned that even better survival rates are possible in the advent of bone scans, radioimmunoassays of acid phosphatase, and regional lymph node biopsies prior to surgery.

Finally, it is clear that although few prostate stage B cancers will be discovered by the primary care physician, each case that is found represents a potential curable cancer.

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Features

Treating the Chronic Mentally Ill: Shifting Priorities 527
Max D. Graves, M.D.
The chairman of the OSMA Committee on Mental Health reports on the shifting changes in treating the chronic mentally ill patient.

The Cardington Disaster ... 530
Carol W. Mullinax
Just how good is your hospital disaster plan? The medical staff of Morrow County Hospital recently had a chance to find out.

Health Planning: A Physician's Look 534
John Devany, M.D.
Health planning may have its problems, but according to this OSMA member, it's one of those necessary evils.

The Passing Days of the Passive Physician 541
Roger Blackwell, Ph.D., and Wesley Johnston, Ph.D.
The day when a physician was the only source of health care in town is rapidly passing. Now it's time to take a look at the market and try to decide where to go from here.

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The Annual Accountants' report by the Committee on Auditing and Appropriations.

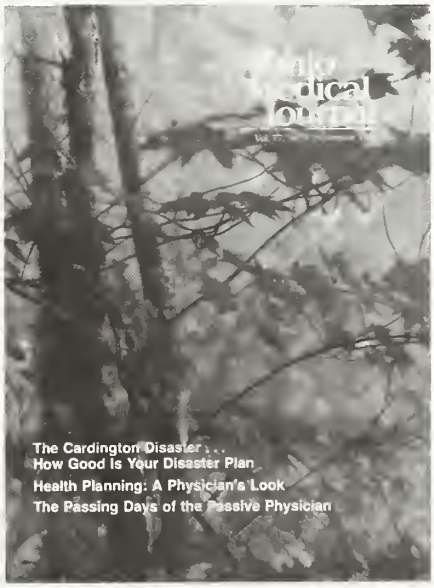
A Little Bit Country 555
Carol W. Mullinax
Music has charms to soothe the savage beast . . . and at least one practice-weary physician.



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Our Cover

Ronald Sokol, M.D., Cincinnati, took an award for outstanding entry in this year's Journal Photographic Contest with his picture of "Autumn Colors."

The high cost of free helath care

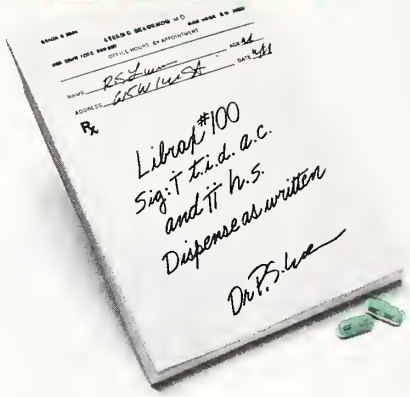
ONE MORE COUNTRY IS LEARNING that a "free health care system" is often "inefficient and inequitable." A Peking newspaper, the China Daily, said recently, "More often than not, those in important positions or on good terms with the doctor can obtain effective medicine while for the rest of us, this is sometimes extremely difficult or impossible." The article also said medicines were often dumped "like rubbish because one can obtain these pills for the asking. No doubt one would think twice about throwing them away if the cost came out of one's own pocket," the newspaper said.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

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***Usage in Pregnancy*: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Letters ...to the editor

To the Editor:

The growing number of analgesic agents attests to the significant numbers of patients with intractable pain, especially in the malignant disease category. The three undersigned pharmacists have developed a simple formula which has impressed this clinician with a remarkable degree of pain relief in difficult situations. A number of patients who were responding poorly to vigorous treatment with a variety of analgesics including Tylenol with Codeine, Dilaudid, Demerol, "Brompton's cocktail" and Methadone tablets have responded promptly to this formula. The effectiveness of this combination seems clearly to indicate synergism of Dextroamphetamine and Methadone. There is more than simple synergism involved which is suggested by the fact that three patients have voluntarily reduced the oral dosage from 5 ml q3h to q12h and then once in 24 hours. Two patients volunteered that they no longer needed analgesia. All of the patients observed had carcinoma with extensive osseous metastases. The formula we have used is as follows:

Methadone 360 mg.
Elixir of Dextroamphetamine 5 mg./5 ml 90 ml
95% Ethanol 45 ml
Flavored Diluent 45 ml
Disp. 180 ml
Containing Methadone 10 mg.
Dexamphetamine 2.5 mg per 5 ml

The synergism of Morphine and Dextroamphetamine reported by Ivy[1] and Evans et al[2] has been supported by the large study of Forrest et al[3] using those two agents parenterally for immediate short-term postoperative pain relief. The accessibility and stability of our orally administered formula is appropriate and effective for home management of cancer patients.

Henry E. Wilson, M.D.
Randy Schad, M.S. R.Ph.
Jerry Siegel, R.Ph.
Meredith Wiley P.Ph.
Ohio State University Hospitals

Continued on page 525

COLLEAGUES IN THE NEWS



Ralph Lach, M.D., Columbus . . . honored alumnus from John Carroll University.



Albert May, M.D., Cleveland . . . serving on the Board of the Institute for Child Advocacy.

RALPH D. LACH, M.D., Columbus, received the alumni medal from the John Carroll University Alumni Association. The medal is conferred annually upon alumni who have, through distinguished conduct of their lives, brought extraordinary credit to the University. Dr. Lach is chief of the division of cardiology of the Mount Carmel Medical Center.

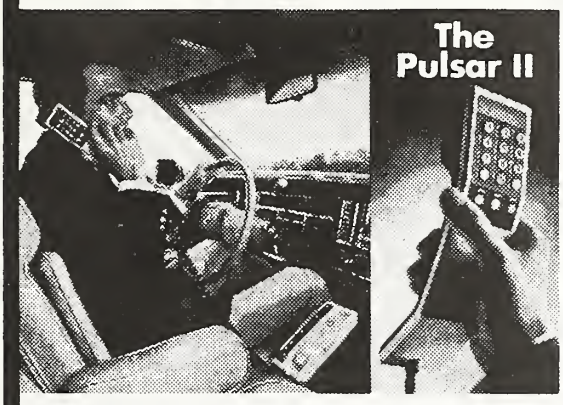
ALBERT N. MAY, M.D., Cleveland, was elected to the board of trustees of the Institute for Child Advocacy. Dr. May currently serves as president of Action for Children, Inc., on the advisory bodies to Ohio's Health Department and Welfare Department and is currently on the Advisory Committee of the National Organizations Advisory Council for Children, New York.

RAVINDER NATH, M.D., Youngstown, was elected president of the Mahoning Valley Chapter of the American Diabetes Association. Dr. Nath practices internal medicine and is on the staff of the Youngstown Hospital Association.

In honor of his long-term dedication to quality health care for children served by Bellefaire-Jewish Children's Bureau, **LEONARD P. ROME, M.D.,** Cleveland, was elected the first trustee emeritus by the board of trustees. Dr. Rome is an associate pediatrician at Mt. Sinai and serves as chairman of its department of pediatric allergy. He is an associate clinical professor of pediatrics at Case Western Reserve University Medical School and serves on the pediatric staff of University Hospital.

MANUEL TZAGOURNIS, M.D., Columbus, was appointed dean of the Ohio State University College of Medicine. Dr. Tzagournis is a professor of endocrinology at Ohio State University. He is the author of approximately 52 research articles and publications and is affiliated with nearly 20 professional associations and societies.

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NEWS

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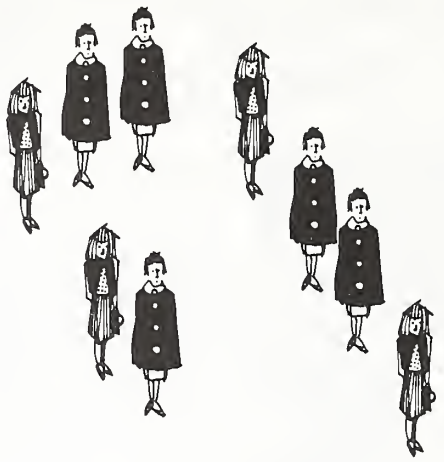
edited by Karen S. Edwards

BOOK SHELF

Drug abuse: A guide for the primary care physician. *The American Medical Association.*

Although this book has been specifically designed to meet the needs of primary care physicians, its concise text, presenting the latest clinical research on drug abuse should prove helpful to all health professionals.

Twelve chapters explore all facets of the problem of drug abuse, its causes, incidence, diagnosis, treatment and prevention — and includes such helpful guides as clinical signs of acute drug reactions; tests to confirm suspected drug use; steps in treatment planning; and state and federal drug abuse agencies. To order a copy, write to: Order Department, OP-323, American Medical Association, P. O. Box 821, Monroe, Wisconsin 53566. Cost of the book is $15, plus $2 for handling.



Where have all the patients gone?

The practice pattern of the nation's physicians is changing and the average MD is seeing fewer patients than in recent years, a new American Medical Association study shows.

The new 10th edition of the *AMA Profile of Medical Practice* reports that physicians last year reported an average of 112 patient visits per week, down from 122.7 visits in 1979 and 130.6 in 1978. The physician's work week, however, isn't changing much: 44.5 hours of direct patient care in 1980, compared with 44.9 hours in 1979 and 45.4 hours in 1978.

The newest edition of *Profile* focuses on trends and changes in the health care system over the past decade. Principal source of the statistics is the AMA's 14th periodic survey of physicians, conducted by the AMA Center for Health Services Research and Development.

The opening article, "Competitive Forces in the Market for Physicians' Services," reviews the issue of competition versus regulation in the physicians' services market. It concludes that marketplace factors, particularly the increasing supply of physicians, tend to limit increases in physicians' fees.

Deflated ego isn't the only problem . . .

A woman with silicone implanted breasts is apt to receive more than a deflated ego, should she receive a blow to that area, reports an article in a recent American Medical Association specialty journal.

The case of a Texas woman whose silicone implants burst after a blow to her chest, was described by James Mason, M.D., of the University of Texas Medical Branch, Galveston, in an issue of *Archives of Dermatology.*

The gel-filled bags, which had been implanted for cosmetic purposes, ruptured after the woman sustained the blow, and the released silicone moved through the body, up the shoulder, and down into the arm, forming a hard, unsightly mass along the upper arm. The breast deflated, appearing smaller than its mate. Plastic surgery was required to remove the material, and to replace the ruptured breast implant.

Silicone used in the gel implants varies in consistency and cohesiveness, depending on the manufacturer, Dr. Mason says. Rupture of the gel-filled implants with subsequent diffusion of leaked silicone can be due to a relatively minor blow to the breast, he points out.

Usually, the patient first notices that something is wrong when the breast suddenly becomes smaller, or notices a lump forming under the skin somewhere else in the body.

Meetings

• The American Medical Association, in cooperation with the American Correctional Health Services Association, will sponsor its Fifth National Conference on Medical Care and Health Services in Correctional Institutions at Chicago's Marriott Hotel, October 30-31, 1981.

Nearly 40 workshops are scheduled in such areas as:

• Risk management and lawsuits
• Health problems of incarcerated women
• Treating the drug offender
• Evaluating jail models

Cancer 1981/2001 — An International Colloquium: November 10-14, Shamrock Hilton Hotel, Houston, Texas. Sessions will include discussions of radiotherapy, chemotherapy and surgery; gynecologic and pediatric cancer; cancer genetics and pain control. For further information, contact Lisa Long or Joan Chin at 713-792-3030.

9TH ANNUAL COMBINED MEETING OF THE OHIO CHAPTER OF THE AMERICAN COLLEGE OF PHYSICIANS AND THE OHIO SOCIETY OF INTERNAL MEDICINE: September 10-12; The Daytonian, Dayton; 10 hours Category I credit; sponsored by the American College of Physicians; fee: $100 ACP and OSIM members; $125 nonmembers; house staff exempt; contact: Ms. Vickey McVay, Ohio Society of Internal Medicine, 600 South High Street, Columbus, Ohio 43215, 614/228-6971.

42ND ANNUAL MEETING OF THE OHIO SOCIETY OF ANESTHESIOLOGISTS: September 25-27; Sheraton-Columbus Hotel, Columbus; 9 hours Category I credit; sponsored by the Ohio Society of Anesthesiologists, Inc. and the Ohio State Medical Association; fee: no cost OSA member; $40 nonmember physicians; $20 nonmember allied health personnel; contact: Ms. Vickey McVay, Ohio Society of Anesthesiologists, 600 South High Street, Columbus, Ohio 43215, 614/228-6971.

Cookies show Feingold diet ineffective

The Feingold diet isn't effective as a cure for hyperactivity in children, says a report in the current issue of the AMA's *Archives of General Psychiatry.*

The diet, which eliminates artificial food colorings on the presumption that the additives are responsible for hyperactivity in small children, was advanced by Ben F. Feingold, M.D., and has been widely used in treating hyperactivity.

In the study, children were provided as placebos cookies made of natural ingredients of the type recommended in the Feingold diet and another supply identical with the placebos but containing a mixture of all FDA-approved artificial food colorings reflecting normal patterns of consumption.

Children received both the active and placebo cookies for one week each, separated by a week with no cookies.

Evaluation by parents, teachers, and psychiatrists and psychological testing yielded no evidence of a food coloring effect on hyperactivity, Dr. Mattes said.

Reusable photographic plates will lower costs of x-rays

Scientists have developed an x-ray technique they say will cut costs, decrease patient exposure, and simplify storage of test results.

The system, which uses a computer and selenium-coated photographic plates, will be prototype-tested in about a year, with marketing expected in approximately two years if all goes well, said Alfonso Zermeno, PhD, physics professor at the U. of Texas M.D. Anderson Hospital and Tumor Institute in Houston.

Costs can be decreased because the reusable photographic plates replace x-ray film. Once the plate is exposed using standard x-ray equipment, the image is stored in a computer and the plate used again. A small photographic print can be made for documentation instead of storing large x-rays.

A physician can use the computer to manipulate or improve the image, which sometimes can eliminate the need for retakes, series, and large sheets of x-ray film.

These features also will decrease patient x-ray exposure 10 to 300 times, researchers estimate.

Letters to the Editor (continued)

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Pnapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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An OSMA committee report

Treating the chronic mentally ill: Shifting priorities

By Max D. Graves, M.D.

There is increasing concern in many communities of Ohio and the nation regarding the provision of medical/psychiatric care and meeting the needs of chronic mentally ill patients. This concern is given high priority by the medical profession.

The House of Delegates of the American Medical Association adopted a resolution at its 1978 annual meeting and approved a report in December, 1979, dealing with this issue and recommending programs "to stress the importance of increased physician awareness and participation in resolving the medical problems of the chronic mentally ill in the community." The Council of OSMA has directed attention to similar concerns within the state.

Nationally, the state hospital population has decreased from a peak of 560,000 in 1955 to about 150,000 at present. In Ohio, it has dropped from 28,367 mentally ill patients in 1955 to 4,905 as of late July, 1981.

This major social process, termed deinstitutionalization, has been and continues to be a major impact on the care of the chronic mentally ill population. This significant decrease in institutional care has been greatly influenced by technological changes, particularly the introduction of phenothiazines.

Likewise, community mental health philosophy of the '60s and '70s and the growing civil rights sensitivities resulting in major revisions of statutes dealing with patient commitment and involuntary hospital care and treatment were also major influences in the acceleration of this process. State fiscal problems and the need to shift funding to local and federal programs were contributing factors.

Max D. Graves, M.D., is in private practice of psychiatry in Springfield. He is chairman of the OSMA Committee on Mental Health and a past president of the Ohio Psychiatric Association.

Since 1975 there has developed increasing community concerns and at time alarm over the problems resulting from this process. Often it seems the results have been equally dehumanizing as the institutional life problems so thoroughly documented. There has been increasing documentation in news reports and elsewhere of the problems and inadequacies faced by the mentally ill living in boarding homes, residential hotels, halfway houses, nursing homes or perhaps "on the street." Even when returned to their own home and family the conflicts and dissatisfactions may give rise to stress reactions in family members as well as the patient.

The turning point

Perhaps a turning point in the attitude and thinking of professionals confronting these issues was the National Conference on the Chronic Mental Patient held in Washington, D.C., January 11 to 14, 1978, sponsored by the American Psychiatric Association and the President's Commission on Mental Health. Included in the final report of the President's Commission are references to "a national priority to meet the needs of people with chronic mental illness."

Over the past three years there has been presented, with increasing frequency, in all the mental health literature, various viewpoints and proposals to identify these needs and organize the resources necessary to confront the problems.

Obviously, one of the important needs of this group of citizens is for adequate, skilled medical/psychiatric care, which often is not readily available. Chronic mentally ill patients have a higher incidence of medical problems than the general population but have difficulty making use of medical resources. John Talbott, M.D., has estimated that of this population discharged from institutions, less than 25% continue active in an organized treatment program and fewer than 50% continue on medication. It is reported that 50% of the mental health treatment nationwide is provided by or under the direction of primary care physicians. Although patients discharged from state mental hospitals comprise a large portion of this population, Bertram Pepper, M.D., Director of the Rockland County Mental Health Center in Pomona, N.Y., and others have recently described the increasing numbers of young adults with chronic mental illness who have never been in long-term institutional care and who present a special challenge to the therapeutic efforts of the community.

In response to a felt need in Ohio, the Committee on Mental Health of OSMA has initiated cosponsorship with the Ohio Psychiatric Association, the Ohio Academy of Family Physicians, the Ohio Department of Health and Ohio Department of Mental Health to develop a one-day workshop entitled, "New Priority on Treatment of the Chronic Mentally Ill," for Wednesday, October 28, 1981, at Stouffer's Dublin Inn, near Columbus.

Workshop objectives

The established objectives are as follows:

I. To establish a continuing education forum for physicians caring for medical/psychiatric aspects of chronic mental illness.

II. To identify the need for physicians in both primary care and psychiatry to gain new interest and establish priority in treating chronic

mental illness to the same extent as chronic physical illness.

III. To identify techniques to enable the busy primary care physician to meet a significant portion of the mental health needs of his patients.

IV. To identify facilities and support organizations in the community and region with activities directed toward treating chronic mental illness.

V. To encourage medical educators to place more emphasis on chronic mental illness in medical school curricula and in primary care and psychiatric residency programs.

The **New Priority** reference in the workshop title refers to the new numbers of chronic mentally ill patients in the community as a result of deinstitutionalization, new community concerns for these persons, and to the new commitment of the medical and allied mental health professionals to come to grips with the complex issues involved in this problem.

This workshop may be the first of a series directed toward increasing the likelihood that community mental health will be effective in Ohio.

Further information on "New Priority on Treatment of the Chronic Mentally Ill," including preregistration forms, is available from the Committee on Mental Health, Department of Health Education, OSMA, 600 South High Street, Columbus, Ohio 43215.

Application has been for both Category I CME credit and AAFP/OAFP continuing education credit.



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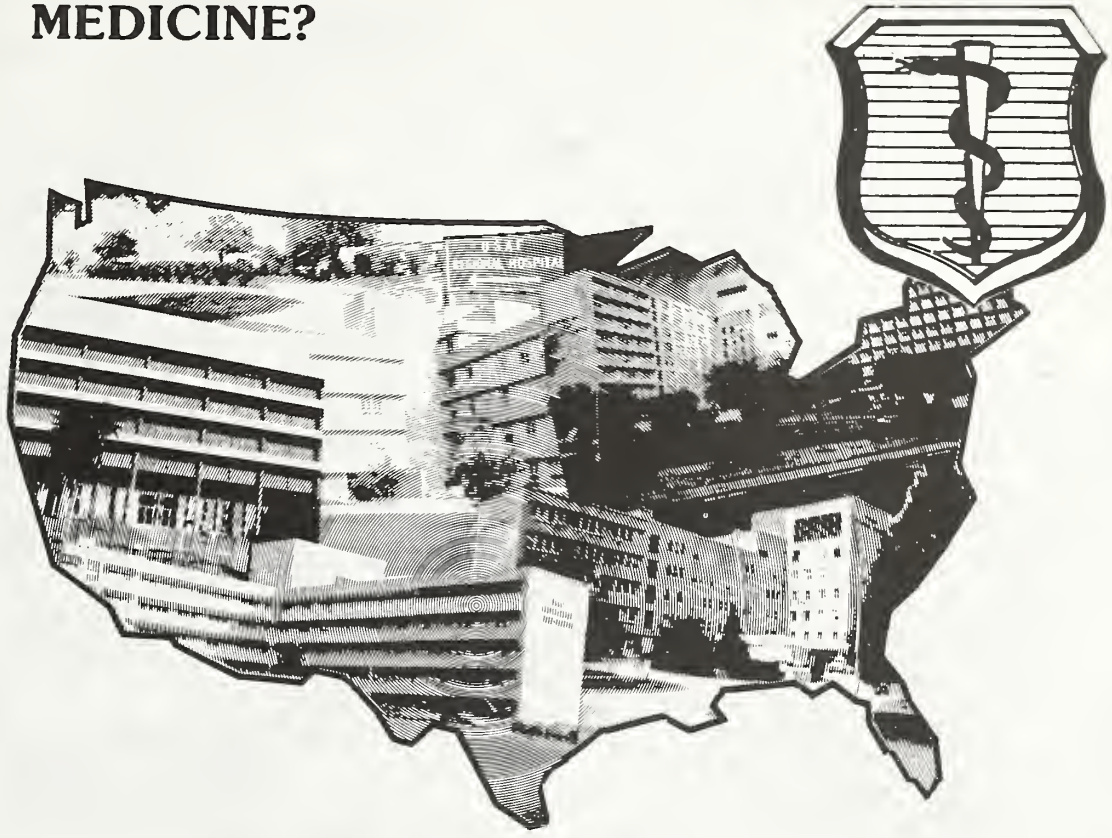
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When a tornado recently struck the small town of Cardington, Ohio, local physicians had a chance to find out just how good their hospital disaster plan really was. (All photos courtesy of the Morrow County Sentinel.)

The Cardington Disaster

By Carol W. Mullinax

With barely 2,000 people, Cardington is the type of rural, peaceful farm community that never expects to make the front page of a major newspaper or be highlighted on the evening news. But on July 13th the eyes of the state focused on this small Ohio town when a tornado, traveling down Main Street, left four people dead, dozens injured and the business district in ruins.

It was a test of individual courage and determination that Cardington residents passed with flying colors. But the average person flicks off the evening news or throws down the newspaper without realizing that a tornado or any disaster prompts another more critical test.

For the Morrow County Hospital, the question was: Could it meet the demands placed on it by a real-life, full-scale disaster? It is a question that all hospitals anticipate, but hope they never have to answer.

But that Saturday, an answer was needed. . .and needed urgently.

John D. Harbaugh, the administrator of Morrow County Hospital, and David James Hickson, M.D., a family practitioner who served as triage officer during the emergency, were relaxing at home, keeping a watchful

eye on the darkening sky, when the tornado struck.

Cardington's fire chief quickly actuated the county alarm system, beginning a flurry of activity at the hospital. Harbaugh was notified, and he, in turn, implemented the first phase of the hospital's emergency disaster plan.

Personnel present at the hospital were counted, then additional physicians and staff members were notified and put on stand-by alert. When the first emergency vehicle with six victims roared toward the hospital, stand-by staff were told to report.

Dr. Hickson had just returned from the wedding of a friend, and was enjoying a visit with his daughter — a senior medical student at the University of Cincinnati School of Medicine — when the call came. He and his daughter reported immediately.

At 3:50 P.M. approximately 25 minutes after the tornado touched down, the first victims began to arrive. For the next six hours the personnel at Morrow County Hospital — seven local physicians, several volunteer physicians from surrounding counties and countless staff people — worked diligently, treating the injured.

Finally, the grim statistics were in. Fifty-three had been treated, 11 admitted, and tragically four were dead. For the 83-bed rural hospital, it had been a trial by fire and it had glowingly withstood the test. Harbaugh says, all modesty aside, he would rate the hospital's performance as "outstanding," but he was even more pleased with the reaction from local residents.

"All of a sudden, instead of being a 'band-aid and referral factory,' they say, 'By god, we've got a hospital out there.'"

Harbaugh is quick to point out, however, that it wasn't a matter of luck. With planning and foresight, both hospital and county were prepared for the disaster.

Morrow County maintains and operates a county-wide dispatch system which electronically alerts all of the county's firefighters, emergency squads, hospital and residents with one push of a button. Although the tornado appeared too suddenly to allow the dispatch system proper time to alert the residents, it was only seconds after the tornado touched down that rescue operations began.

Morrow County Hospital of course had its disaster plan, and in fact had just tested it. Seven months earlier, under this planned "mock disaster," local boy scouts served as the victims of what was reported to be an explosion at a local boy scout lodge. Hospital and emergency squads handled their jobs with surprisingly few difficulties — unless you count the reaction of local citizens.

Although they had been warned that a mock disaster would be held at an unspecified time during a three-week period, the announcement on their emergency scanners caused many to believe it was real. "There are still people in Morrow County who haven't forgiven me for that," Harbaugh says.

But, citizen reaction aside, the trial run did help the hospital evaluate its plan. Based on the problems encountered in the mock disaster, the Safety Committee of the hospital had begun work on a revision when, ironically, the tornado struck.

"Basically, we stayed with the original plan," Harbaugh says, "but we had to do some on-the-scene improvising. If it made sense, we did it," he added.

One problem which did surface, however, was the hospital's initial way of handling the victims. On paper, it looked like a good idea to have three doctors handle triage, but in fact it had the potential of creating havoc. "If three doctors do triage, we suddenly have three patients who need to be moved all at the same time, and we need six litter bearers. I don't have

"All of a sudden, instead of being a 'band-aid referral factory' they say, 'By God, we've got a hospital out there' "



Looking like a bomb had struck it, Cardington's downtown section stands as silent testament to the tornado's damaging winds.

that kind of staff, Harbaugh says. What happened was that triage officer, Dr. Hickson, kept the operation running smoothly. No one was kept waiting and no one area of the hospital was overloaded with patients.

As a result of the tornado, the hospital also plans to change its policy on visitors during an emergency. The original plan called for all visitors to be asked to leave the building. But during the real emergency, Harbaugh says, "We ignored them." In many cases family members helped out by emptying the bedpans and performing other small tasks which helped to free the nurses.

To keep the number of visitors at a minimum, the hospital initiated an "on-the-spot weeding system. All visitors were stopped at the front desk of the hospital and asked to wait in the lobby for injured friends and relatives, since the emergency room was crowded. "At that point," Harbaugh says, "we could tell by the look on their faces whether or not to press the issue and keep them in the lobby or allow them back in the emergency room. He says the process wasn't scientific but it was effective.

"Basically we stayed with the original plan . . . but we had to do some on-the-scene improvising. If it made sense, we did it."

It brings up a major problem, however, that seems to plague all disaster plans — no matter how well thought-out the plan, every contingency will not be covered. As Dr. Hickson points out, "In any disaster plan you operate under the premise that all other departments and people are operating as they should. In some cases, that just doesn't happen." Harbaugh agrees. "How," he asks, "can you write in a disaster plan the look on visitors faces will determine where they wait?"

It is a problem with which they still are wrestling. Harbaugh isn't discouraged with the minor problems the hospital did encounter. "A plan is written, you hold a mock event (or a real one) and the plan is rewritten." But as Dr. Hickson quickly adds, "We only hope we never have enough disaster to perfect the plan."

Carol W. Mullinax is the Associate Director of the Department of Communications, and a contributing editor for the Ohio State Medical Journal

The rebuilding process will be slow for Cardington, but, at least residents now know that their community medical services can cope with any emergency that may come along.



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HEALTH PLANNING: A physician's look

By John Devany, M.D.

As a member of the Board of Trustees of the Area 4 health systems, I was impressed by a line in a recent CSM report which states: *"An essential element in the acceptability of the actions of a community health planning body is the supportive participation of all segments of the community."* It has been clearly shown that where physicians and other providers do not become actively involved in community health planning, other groups have assumed the leadership and attempted to determine the configuration of the health care delivery system in ways which may be disruptive. In figuring the membership of boards, a quota system is foolish. I can say from personal experience that we had more problems with "providers" than with consumers and I would caution you to be very careful in the formation of any new boards. Do not cast in stone your definition of provider and consumer.

"I can say from personal experience that we had more problems with providers than with consumers, and I would caution you to be very careful in the formation of any new boards. Don't cast in stone your definition of provider and consumer."

The biggest problem which the present HSAs have faced has been reconciling its bed count with the government's four-beds-per-thousand regulation — a figure that seems to be without any real scientific basis. Occupancy has been a time-honored measure of hospital efficiency and bed need, but it is a measure principally designed for ease of calculation. Specific indicators of cost, quality, and access are more difficult to develop and interpret but they provide more accurate measures of the appropriateness of a hospital's capacity and use.

McStrovik and Field have suggested in a recent paper that hospital trustees, administrators and planners should give their attention to specific measures of cost, quality and access, as each is affected by the relationship between the amount of use the facility gets and its capacity to accommodate that use. Costs, for example, are affected by the amount of fixed capacity the hospital maintains, regardless of occupancy. Quality may be affected by the sheer amount of utilization and by the necessity of placing patients in units not intended for their particular needs when beds in the appropriate unit are unavailable.

Access is affected by the necessity for denying or delaying admissions when all beds in the hospital are full and by the distance of the nearest alternative.

Thus, instead of occupancy, we should receive reports that reflect such measures as:

1. The amount of fixed cost built into hospital expenses by the hospital's over-all capacity, not necessarily the number of beds per se.
2. How do fixed costs compare with those of similar institutions?
3. The hospital's total space per bed, compared with that of comparable facilities.
4. Extent to which the capacity of the hospital is efficiently used.
5. What percentage of capacity is reached and how often?
6. The extent to which volume of use of particular services is adequate to maintain standards of quality and to generate sufficient income to cover the cost.
7. The frequency with which patients are misplaced or have admissions delayed or denied because of lack of an appropriate bed, or any bed at all.
8. The variability of admissions and census and the staffing and workload problems associated with such fluctuations.

John Devany, M.D., Toledo, is an OSMA member, and an active participant in his area's health planning consortium. The text of this article comes from a speech he gave before a special meeting of the State Health Coordinating Council.

Clearly, monitoring adequacy of hospital capacity and its use, through measures such as these, is more complicated than relying on occupancy alone.

The Robert Wood Johnson Foundation has recently published a report which shows that occupancy rates in small community hospitals have been declining steadily to the point where the occupancy rate in 1979 was averaging 49% across the county. At the same time, rural nursing homes often have waiting lists for admissions so long that some elderly patients must seek long-term care in metropolitan communities far from their families. The possibility of turning acute care beds into swing beds is seen as a way to bolster hospital occupancy rates and provide more extended care facilities at the same time. We are going to have to pay attention to this and to every other means of increasing the efficiency of our product.

The United States enters the 1980s beset with serious economic problems. The picture currently projected from long-term economic forecasts suggests a downturn in our nation's economy and a sharp decrease in monies available for further growth or improvements in America's medical care system. These prospects have serious implications for many of America's most important health care institutions, their health professionals, and how they plan for the future. Developing plans for such a period of constrained resources may help prevent loss of the impressive gains in medical care made during better economic times.

Most efforts at cost control have concentrated on medical services thought to be excessive, such as redundant laboratory tests or unnecessary surgery.

I would strongly recommend to each of you that you become familiar with the recent study of Schroeder and Showstack in the April 10 issue of the *Journal of the American Medical Association*. They try to assess the degree to which high cost illness is terminal illness. Survival data were obtained on a random sample of 776 adult high-cost patients from nine acute care hospitals in the San Francisco area. Two years after discharge at least 34% of high cost patients had died. These patients accounted for 39% of the hospital charges incurred by the total group of patients studied. Among the factors significantly associated with death were:

1. A diagnosis of cancer (62% death).
2. Age older than 64 years (44% death).
3. Discharge from a medical as opposed to a surgical service (42% death).
4. A hospital bill of $10,000 or more (48% death).

Though there was considerable variation in the death rate among the hospitals, the data suggest large amounts of medical care are consumed by patients with unfavorable prognosis. This brings us to a certain set of facts we must face.

1. The expense of caring for the elderly was considerably less a decade ago, and somewhat minimal before that. We are victims of our own success. Life expectancy has increased greatly and with it an accelerating utilization of health care services and facilities by the elderly.

Can this — should this — pattern of care be changed?

2. At the other end of the age spectrum is the advanced knowledge in saving newborns. Twenty-five years ago the average charge in a hospital nursery was about $5 a day; today's highly sophisticated neonatology intensive care centers cost hundreds of dollars a day.

Shall we continue to save lives of babies of high risk mothers or should we return to survival of the fittest?

3. Trauma centers, emergency medical services, sophisticated treatment of the accident victim — these offer one of the greatest areas of opportunity for reducing death rates and extending life expectancy. Yet the treatment of trauma is one of the most costly areas of medical care, one that is climbing at a disproportionate rate.

Shall we continue to make dramatic professional and scientific strides in the treatment of the injured?

4. In recent years solid progress has been made in the treatment or cure of 13 types of cancer. Chemotherapy offers new promise to the age-old quest for a cure of this terrible disease.

"I have long felt that the most pernicious aspect of cost benefit and cost effectiveness analysis is that it conceals difficult moral questions under a comforting pretense of mathematical objectivity."

John Devany, M.D.



The search is promising. If and when that momentous day comes — as some believe it will — it may greatly add to the cost of hospital and medical treatment.

Are we ready to bear that cost or shall we call a halt to the continuing advances in cancer treatment and research?

5. Monitors, defibrillators, pacemakers, cardiac catheterization, open heart surgery, have vastly improved the lot of heart patients. Intensive coronary care units have reduced the deaths from heart attacks to a fraction of those that existed before such technology. Thousands of patients live annually (with large hospital and doctor bills), who 15 years ago would have died.

Shall we roll back the progress, and thereby deescalate health care costs?

6. Today's death rate from kidney disease has been cut in half in a few short years. Renal dialysis centers and increasingly successful kidney transplant surgery offer hope to many thousands facing certain death a few short years ago. But the expense is great.

Are we prepared to withdraw that hope?

7. Great sums are expended on the care of patients whose health problems have been accurately called diseases of choice — because they are only preventable through the process of personal decision making, such as smoking, drinking, the manner of driving their cars, personal living habits, stress situations, etc.

Shall we continue to pay the ever-increasing expenses for those whose lives involve excessive use of these agents and indifference to safety measures?

These points reinforce my concern that we don't know how to measure the benefits of these programs accurately, nor do we have a valid method of measuring the true cost of death and disease. I have long felt that the most pernicious aspect of cost benefit and cost effectiveness analysis is that it conceals difficult moral questions under a comforting pretense of mathematical objectivity.

There are proposals for a sweeping reorganization of the medicare-medicaid system. I suggest to you that this assumes a preoccupation with price. Certainly price is an important factor, but equally, if not more so, are access, reliability and quality as perceived by the patient.

The proposal made by the Reagan administration to accompany the 5% cap on federal medicaid expenditures in the fiscal year with a measure restricting the freedom of choice for medicaid beneficiaries would have a devastating result on the poor.

The plight of the poor would be even further aggravated by another administration proposal to eliminate current reimbursement requirements in the medicaid law. If medicaid beneficiaries are to remain eligible for quality care, then it is important for all providers to receive reasonable reimbursement.

Any system under which medicaid recipients have their freedom of choice restricted would result in an officially sanctioned, dual system of health care — one level of services for the poor — and a superior level of choice and options for everyone else.

We are going to be facing an almost immediate crisis in the delivery of health to the poor in Ohio. The present state budget carries in it a provision that the amount paid by medicaid for an outpatient clinic visit to a hospital, will not exceed the amount paid for a visit to a doctor's office. But hospitals are much more expensive to operate than physicians' offices — and if this provision is adopted it will wreak havoc with the inner city hospitals in Cleveland, Toledo and Cincinnati. For instance, 62% of the medicaid patients seen in Toledo are seen at St. Vincent Hospital and Medical Center. If this is forced to cut back or go bankrupt, where will the poor go?

The Ohio State Medical Association has entered into a joint effort with the Ohio Hospital Association and the Ohio Osteopathic Association to try to bring some intelligent agreement. A statement of purpose and subsequent objectives was drawn up by the committee and recently approved by the Council of the Ohio State Medical Association. These are as follows:

STATEMENT OF PURPOSE

The Joint Committee believes that health planning is the provision of efficient planning services to the community or region served for purposes of:

1. Assisting in the improvement of the health status of residents of the area.

2. Providing assistance and support to health care institutions and entities in developing the appropriate mix of health care services.

3. Promoting the quality, availability, accessibility, and continuity of health care services at a cost consistent with these requirements.

The Joint Committee recommends that there be an organization through which hospitals, physicians, other health care providers, business, industry and labor cooperate to provide for effective, continuous communications between state level voluntary and governmental agencies and between state and local groups relative to planning activities.

OBJECTIVES

1. To develop public understanding of the importance of voluntary community-based health planning and to guide and assist in its development.

2. To define specific health planning problem areas and to seek solutions to them.

3. To encourage all health care providers, appropriate professional, public and private organizations and governmental bodies to participate in local planning activities.

4. To promote the appropriate improvement of health care facilities and services.

5. TO SUPPORT ENACTMENT OF LEGISLATION WHICH WOULD EXEMPT INDIVIDUALS AND THE CORPORATE ENTITIES WHICH THEY MAY REPRESENT FROM THOSE FEDERAL AND STATE ANTITRUST LAWS WHICH MAY BE APPLIED TO VOLUNTARY HEALTH PLANNING ACTIVITIES.

The power and authority of a community-based mechanism is inevitably weakened by involvement in regulatory processes or through the exercise of decision-making authority. The protection of the public welfare is properly a concern of government and activities to protect the public may be implemented in a variety of ways. However, local voluntary health planning is a creative process and, therefore, should not necessarily include the use of regulatory sanctions.

I would like to call to your attention that the Ohio State Medical

Continued on page 545

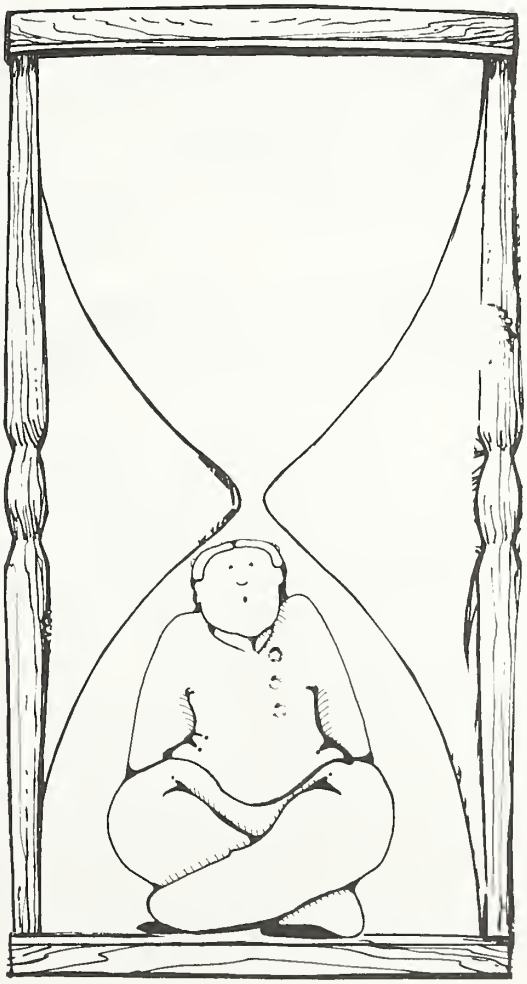
"To market, to market . . ."

The passing days of the passive physician

Roger Blackwell, Ph.D.
Wesley J. Johnston, Ph.D.

Until recently, government regulation had been considered the principal means, if not the only means, to reduce duplication of medical facilities and fragmentation of services, stabilize price rates, and improve levels of minimum standards in patient care. This belief encouraged the proliferation of mechanisms such as certificate of need programs, professional standards review organizations, and rate setting. National Health Insurance was seen as an inevitable outcome of increasing regulatory efforts even by the American Medical Association. Now, however, regulation is coming under attack from more and more directions as inflationary, antiproductive, and inevitably crippled by red tape and exemptions that are costly to administer. Critics of direct government regulation agree that regulation has not accomplished its goal to curb overutilization and unnecessary growth or to provide quality medical care at a reasonable cost. Other parallel approaches which have been tried — indirect regulation and voluntary control — attempted to contain costs but produced mixed results and are slowly losing ground. Another alternative — competition — has aroused a great deal of interest within the Federal Government and the health care sector. This interest in moving away from increasing regulation toward stimulating competition among health care providers comes at an interesting time when certain trends in the supply and demand for health care would seem to be appropriate for the support of a competitive environment. The concept of competition is based upon the premise that individual consumers, making diverse decisions in their own economic self-interest in an open marketplace, will end up solving collective societal problems more effectively than governmental controls would — and more efficiently — thereby cutting costs. Adam Smith, the great economist, referred to this phenomenon as the "invisible hand" of the market but excluded health care from normal markets. The health care market has had several distinct characteristics and competition in health care was not competition in the economic sense. But many feel this has changed and competition in health care can result from the introduction of certain specific mechanisms into the system to encourage people and institutions to behave differently from the way they have traditionally behaved.

Every physician in Ohio currently has a strategy . . . whether they have thought of it in this way or not.



The future is uncertain but change is very likely. Forecasting future events is, at best, an imperfect science. Yet those persons or organizations who can most accurately foresee the possibilities of the future are generally best able to adapt to it. While there is not a physician in this country who can change the environment, every physician will have to change if the environment changes. An individual or organization can change strategy to fit the environment, but the environment cannot be changed to fit the strategy. If the Ohio State Medical Association and its individual members want to develop the strategies that are right for the 1980s, the place to start is not with what they as an organization or individual physician want to be in the 1980s, but by looking at what the environment



Authors Wesley Johnston (left) and Roger Blackwell presented their Marketing and Competition study at this year's Annual Meeting this past May in Cleveland, Ohio.

will be and then developing an appropriate strategy to achieve the best in health care delivery in that environment.

This article examines the various forces and trends currently present in the environment of the health care industry, and attempts to provide specific strategies for the members of the Ohio State Medical Association and the Association itself.

with respect to the industry.

4. The attitudes of the consumers served by the industry.

At this point it is appropriate to investigate each of these environmental factors individually to determine the effect on the health care industry during the next decade.

The Demand for Health Care

Population growth in the United States has been less than 1% per year since 1971. Fertility has been decreasing and is approaching zero population growth (ZPG). The under 18 years of age population segment will decline by 7% in the next 20 years, and in Ohio the number of young people will decline even more than in the nation as a whole. However, the number of elderly has been increasing because of a number of breakthroughs. These breakthroughs have been in the areas of providing full life technologies, enabling more people to live into their older years and life-extending technologies which allow people to live past what had been regarded as the maximum age. Improvements in the first category almost inevitably have some effect on the second. Infant mortality has been decreasing and is currently less than 14 deaths per thousand births. Life expectancy has been increasing and currently is over 73 years of age. In general, the total population of the United States is healthier today than at any time in the history of the country. More is known about proper diets and the importance of exercise in a total health care program.

The post World War II baby boom segment of the population is between the ages of 25-35 — ages traditionally the healthiest of a person's life. It will be another 30 years before this large segment of the population begins to move into the retirement years when health care needs tend to increase.

Finally, something that affects the demand for health care in Ohio specifically, is the mass population movement to the sun belt states — California, Arizona, Texas and Florida. This movement has been primarily at the expense of Northeast and Northcentral states, including Ohio. Every city in the Northeast quadrant of the United States has stopped growing, with only one exception — Columbus, Ohio. Cleveland has seen a mass exodus of both people and companies. Cincinnati has remained at the same population level indicating no growth. The net effect of demographic trends is that the demand for medical care in the state will remain relatively stable over the next ten years.

"While there is not a physician in this country who can change the environment, every physician will have to change if the environment changes."

Today the health care industry is the third largest sector of the economy behind only construction and agriculture for total dollars generated. Expenditures for health care exceeded $212 billion last year. In 1980 the average income for a physician was $83,000 — the highest average income of any group in the world.

But the future of any industry is primarily affected by four factors in the environment:

1. The demand for the industry's product or service.

2. The industry's ability to supply its product or service.

3. The role the government takes

STRATEGIES
Timing and Deployment of Resources

Begin now to accomplish in:	Physician Member Individual Strategies	OSMA Collective Strategies
Short-Term (1-2 years)	Evaluate patient/consumer orientation	Publicize and reinforce consumer/patient orientation
	Improve office management/marketing procedures	Encourage CE courses on office management/marketing topics
		Provide marketing audit
		Assist medical schools with office management/marketing materials
		Provide employer/third-party technical assistance
Medium-Term (2-5 years)	Consider forming appropriate groups	Monitor supply/demand by county and SMSA
	Cooperate with HMOs/IPAs	Improve location/manpower planning service
	Evaluate appropriate specialty/general medicine blends	Study and provide technical recommendations for use of paraprofessionals (DAs and NPs)
	Consider moving to "underdoctored" areas of state	Define "unfair" competition standards
	Educate patients about role of physicians/ specialists/paraprofessionals	Provide members with consumer education/competitive tools
		Establish Group/Individual/Physician Liaison Committee
		Arbitrate inter-group conflicts
Long-Term (5-10 years)	Continue to monitor economic/competitive trends	Continue diligent lobbying
	Periodic evaluation of patient service and attitudes	Develop third-party relationships
	Community development	Assist in dealing with hospitals
		Develop philosophy of physician as "patient's advocate"

The Supply of Health Care

In 1960 there were about 144 physicians per 100,000 people in the United States. In 1970 the Federal Government estimated there was a shortage of 50,000 physicians. The solution was to stimulate the growth of first-year enrollments in medical schools and to increase the number of accredited medical colleges. By 1975 there were over 177 physicians per 100,000 population. In 1976 the government felt the problem had been solved. The Health Professions Educational Assistance Act stated, "There is no longer an insufficient number of physicians and surgeons in the United States." As a result, the law terminated some incentives to medical schools to expand first-year classes and restricted immigration of foreign physicians. Today we currently have about 200 physicians for every 100,000 people and by 1990 the estimate is that there will be over 240. In total number there is expected to be 594,000 physicians in the United States in 1990. the estimated requirements for physicians in 1990, and this is controversial, is 543,000. Thus, the figures indicate that in 20 years we will have gone from an estimate shortage of 50,000 physicians to a surplus of the same amount.

The supply of physicians in Ohio is about equal to the average for the total United States. Ohio ranks 25 among the 50 states and the District of Columbia for physicians per population. Add to this foreign medical graduates, nurse practitioners, physician assistants, chiropractors, naturopaths, and others. The supply of medical care is rapidly expanding and will continue to do so for the next ten years.

The Role of the Government

The Federal Government is moving away from any type of national health insurance plan and regulation in general is being decreased. In the place of regulation the government contemplates substituting competition. The National Health Care Reform Act of 1980, sponsored by former Representative David Stockman and Representative Richard Gephardt, was introduced at the beginning of the 1981 Congressional Session. The bill

YOU HAVE A COMMITMENT TO CONTAIN COSTS.

SO DO WE.

As a physician, you have first-hand knowledge of cost containment. You live with it every day. So do we.

And we share a concern that the high quality of care available to the public not be jeopardized by rising costs. It will take a concerted effort on the part of insurers, physicians and the public to maintain high quality care at a reasonable cost.

At OMIM, cost containment is a commitment to action. To do more than pay claims efficiently. To be concerned that the services we pay for are appropriate, necessary and economical.

These are the goals of the OMIM Medical Necessity Program. Through this Ohio State Medical Association-supported program, certain diagnostic and surgical procedures, identified as outmoded or ineffective by medical specialty societies, are no longer paid routinely.

Claims for these services are paid only when accompanied by documented evidence that they were appropriate and medically necessary under the circumstances.

If there are questions about a decision, the claim will be referred to the relevant specialty society for review.

For more information about the Medical Necessity Program, contact your area Professional Relations office or contact OMIM Provider Affairs, P.O. Box 425, Worthington, OH 43085.

Cost Containment. It's a commitment we share.

HIGH QUALITY, REASONABLE COST... A SHARED RESPONSIBILITY.



Blue Shield
Ohio Medical Indemnity Mutual Corp.

would eliminate government-mandated health planning and phase out the Medicare and Medicaid Programs. HMOs would compete on equal terms with other health care and insurance providers. All Americans would be covered but its success depends on the working, middle-class sector. Most workers would be offered a number of health insurance plans and still be able to choose among providers. The plans would be partially paid for by employers but there would be a price and income tax incentives for workers to choose plans that offered a basic package of benefits for the lowest price. The bill, if enacted, would break the link between jobs and health insurance, a link which has been an important barrier to the entry of new health plans in the market. This and other forms of legislation that are pending could increase competition between health care providers. In addition, a number of recent antitrust rulings concerning American Medical Association ethnical standards in the areas of advertising and pricing could stimulate forms of competition.

Consumer Attitudes

A recent Gallup poll conducted for the AMA indicated 66% of those surveyed felt rapidly rising health costs was the most important issue facing the health care industry. This may give some indication of the consumers willing to support legislation that would bring about competition and a possible decrease in costs. Fifty-six percent of those surveyed felt they were satisfied with their last visit to a medical doctor, only slightly more than half. Forty-one percent were unable to obtain an appointment with a physician within three days when an illness was involved. Twenty-six percent had difficulty in seeing a new doctor. With respect to prices, consumers believed most family doctors charge about the same. Only 2% strongly agreed that they would feel less confident going to a doctor who charged less than others. Seventy-five percent did not agree with the statement that the best doctors charge the most. Economists have believed that if competition does come to the health care industry, price will be the prime factor of competition. That does not appear to be the case as only a third of patients know what their doctor charges before going. Nonprice competition — or service to patients — will be the more important form of competition in the future, in our view.

WHAT LIES AHEAD FOR THE PHYSICIAN

The above indicates that there is both good news and bad news for the Ohio physician. The good news is that a National Health Insurance will probably not come about. The bad news is that competition between physicians for patients and between various organizations and alternative health care delivery systems for control of the industry will most probably take place.

Physicians must make the choice to be active participants in attempting to shape their futures by developing strategies appropriate for a highly competitive environment. The Ohio State Medical Association can aid their members in a number of ways. The table shown indicates short-, medium- and long-term strategies for both individual physicians and OSMA as a group. This table is an outline of the major activities that should be considered by physicians; additional articles might be needed to explain each topic mentioned in the table, but this outline should serve to suggest the topics that should be considered now, both by individual physicians and the appropriate committees of OSMA.

CONCLUSION

What needs to be done is to look at the health care environment of the coming decade and the appropriate physician strategy. If we look at the health care environment we can see quite a few things that are occurring. In thinking about the environment of the 1980s leading up to 1990, we could approach this in a number of ways. For instance, we could approach the future with a belief in inevitability, but we really do not believe the future is such an affair. Good futurologists do not really "predict" what is going to happen in the future. They look at a variety of things that could happen and decide what can be done about bringing about the alternative that society would best benefit from, providing both order and efficiency. To do this we need to think strategically, which is not the way people tend normally to think. Strategy can be defined as a "decisive allocation of resources in a given direction." Using that definition, every physician in Ohio currently has a strategy, whether they have thought of it in this way or not. So also does the State Medical Association have a strategy, and the American Medical Association. They have committed their resources in some direction. The question is, is it the right direction? It is very important to examine where a particular strategy will take you. In the past it really was not necessary to have a business strategy for a physician. A physician practiced medicine and a "good practice" meant the good practice of medicine. It is not that such a philosophy will be changed at all, rather it is that "good medicine" will need to be supplemented by additional communication and adopting skills necessary in a competitive environment. This article and the research underlying it is designed to provide a base from which physicians and their professional organizations can develop the strategic planning likely to result in a health care environment in the future, mutually beneficial for both physicians and patients. OSMA

Health Planning (continued)

Association has gone on record as recognizing that certificate-of-need legislation must be passed in Ohio to comply with Federal health planning amendments, and they have recommended state legislation contain no provisions that would make it more stringent than federal requirements.

CLOSING

Isadore Levine put it very well when he said, "With continuing cost pressures, physicians and hospitals will be forced to develop priorities for programs to support." This raises the spectre of rationing and forces an awareness of the importance of greater areas of cooperation. Even that terrible word, "regionalization," offers a possible solution.

These are watershed years we are facing. Our challenge is to preserve the best of what we have.

Report on the Examination of Financial Statements for the Years Ended December 31, 1980 and 1979

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheets of Ohio State Medical Association at December 31, 1980 and 1979 and the related statements of operations and undesignated net worth and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of the Ohio State Medical Association at December 31, 1980 and 1979 and the results of its operations and changes in financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Columbus, Ohio
March 17, 1981 *Coopers & Lybrand*

OHIO STATE MEDICAL ASSOCIATION
BALANCE SHEET, December 31, 1980 and 1979

ASSETS

	1980	1979
Current assets:		
Cash and cash equivalents	$1,052,857	$1,206,341
Accounts receivable	90,032	50,412
Prepaid expenses	35,573	22,041
Total current assets	1,178,462	1,278,794
Other assets:		
Restricted funds for designated purposes (Note 11)	304,811	
Investments:		
General Trust Fund, at cost which approximates market	48,881	49,012
Physicians Insurance Company of Ohio (PICO), at cost (Notes 8 and 9)	100,000	100,000
Real estate (land — $43,775, building — $41,225) (Note 6)	85,000	
Prepaid conversion costs on computer installation, net of $24,292 amortization in 1980 (Note 1)	36,438	48,584
	575,130	197,596
Property and equipment, at cost (Notes 1 and 2):		
Building	531,776	526,091
Data processing equipment	111,714	111,714
Furniture, fixtures and equipment	110,796	90,362
	754,286	728,167
Less accumulated depreciation	(183,397)	(136,965)
	570,889	591,202
Land	289,113	289,113
	860,002	880,315
	$2,613,594	$2,356,705

The accompanying notes are an integral part of the financial statements.

OHIO STATE MEDICAL ASSOCIATION
BALANCE SHEET, December 31, 1980 and 1979

LIABILITIES AND NET WORTH

	1980	1979
Current liabilities:		
Accounts payable	$114,666	$ 92,027
Installment payable, real estate investment (Note 6)	42,500	
Current portion, term debt (Note 2)	25,527	21,549
Other current liabilities	475,241	457,285
Total current liabilities	657,934	570,861
Term debt (Note 2)	146,098	157,816
Deferred income:		
Annual membership dues (Note 1)	211,048	244,580
Life membership dues (Note 1)	40,200	42,300
Other		3,455
	251,248	290,335
Net worth (Notes 7 and 10):		
Designated funds (Note 11)	304,811	
Undesignated funds	1,253,503	1,337,693
	1,558,314	1,337,693
	$2,613,594	$2,356,705

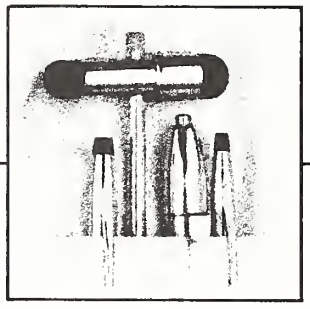
The accompanying notes are an integral part of the financial statements.

STATEMENT OF OPERATIONS AND UNDESIGNATED NET WORTH
for the years ended December 31, 1980 and 1979

	1980	1979
Income:		
Membership dues (Note 1)	$1,795,523	$1,785,093
Exhibit fees	5,750	22,780
Annual meeting	20,880	32,033
Fees for collection of AMA dues	8,597	18,158
CME accreditation and courses	6,098	2,005
Ohio State Medical Journal (Note 7)	135,437	136,874
Interest	186,928	94,371
General trust income (loss)	4,869	(1,168)
Rental income	14,936	20,456
Other	40,358	5,477
	2,219,376	2,116,079
Departmental operating expenses:		
Administration	330,447	358,891
Education and meeting management	257,087	225,788
Health education	102,198	80,725
Field service	78,657	66,099
Fiscal and membership	255,155	221,189
Government relations	148,639	200,452
Communications	450,820	366,359
Organization services	148,134	142,688
State and Federal Legislation	227,618	196,982
Malpractice Research Fund		8,700
	1,998,755	1,867,873

Continued on page 551

An Important Question for Ohio Physicians:



WHEN YOU HAVE A PROFESSIONAL LIABILITY CLAIM, HOW DOES YOUR INSURANCE COMPANY RESPOND?

DOES YOUR COMPANY:

- Use the most highly-qualified, eminent defense counsel available in your area?
- Have a physician's consent clause for claims' settlements?
- Make it a practice *never* to surcharge you next year for this year's claims?
- Have a proven track record of skilled claims handling?
- Have a claims' review committee consisting of doctors?

IF YOU CAN ANSWER YES TO THESE QUESTIONS, YOUR COMPANY IS PROBABLY PICO!

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Call or write for more information; or contact your local PICO agency.

PICO

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Pickerington, Ohio 43147
(614) 864-7100 or toll free in Ohio, 1-800-282-7515.

Net income from operations	220,621	248,206
Net worth, beginning of year	1,337,693	1,089,487
Transfer to designated funds (Note 11)	(304,811)	
Undesignated net worth, end of year	$1,253,503	$1,337,693

The accompanying notes are an integral part of the financial statements.

STATEMENT OF CHANGES IN FINANCIAL POSITION
for the years ended December 31, 1980 and 1979

	1980	1979
Source of funds:		
From operations:		
Net income	$ 220,621	$ 248,206
Depreciation and amortization not requiring working capital	58,578	54,108
Increase (decrease) in deferred income (net of $2,100 amortization of live memberships)	(39,087)	105,814
Additional long-term indebtedness	99,310	
Write-off of accounts receivable from MAI		75,217
	339,422	483,345
Application of funds:		
Acquisition of property and equipment, net	26,119	55,340
Investment in real estate	85,000	
Increase (decrease) in General Trust Fund	(131)	332
Repayment of term debt, net of conversions to current	111,028	21,549
Conversion costs of computer installation		21,953
Funds restricted for designated purposes	304,811	
	526,827	99,174
Increase (decrease) in working capital	$(187,405)	$384,171
Changes in the components of working capital:		
Increase (decrease) in current assets:		
Cash	$(153,484)	$638,164
Accounts receivable	39,620	12,577
Investment, Ohio Medical Indemnity, Inc.		(56,000)
Prepaid expense and unamortized costs	13,532	(892)
	(100,332)	593,849
Increase (decrease) in current liabilities:		
Accounts payable	22,639	(6,654)
Current portion, term debt	3,978	1,652
Installment payable, real estate investment	42,500	
Other current liabilities	17,956	214,680
	87,073	209,678
Increase (decrease) in working capital	$(187,405)	$384,171

The accompanying notes are an integral part of the financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1. **Accounting Policies:**
The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.

a. Depreciation:
Depreciation and amortization are recognized on the straight-line and declining-balance methods in amounts adequate to amortize costs over the estimated useful lives of the assets as follows:

Buildings	40 years
Data processing equipment	5 years
Furniture, fixtures and equipment	10 years
Prepaid conversion costs on computer installation	5 years

Depreciation and amortization charged to operations amounted to $58,578 in 1980 and $54,108 in 1979.

b. Deferred Membership Dues:
Income from annual membership dues is recognized in the calendar year to which they apply. Life membership dues income is recognized over 25 years of active practice of the life membership participants.

2. **Term Debt:**
Term debt at December 31, 1980 consisted of the following:

8% Mortgage loan payable in monthly installments of $2,427, including interest, collateralized by land and building, and due July 1, 1984	$ 86,406
8% Mortgage loan payable in monthly installments of $500, including interest computed semiannually, collateralized by land and building. OSMA has the right of prepayment of principal not to exceed $10,000 per annum, noncumulative, for the first five years. After five years, OSMA has an unlimited right of prepayment	71,410
14¼% Commercial note payable in sixty monthly payments of $360, including interest, collateralized by the equipment purchased. OSMA has the right of prepayment	$ 13,809
	171,625
Less current portion	25,527
	$146,098

3. **Due from Medical Advances Institute:**
In prior years, the Association advanced $75,217, primarily noninterest bearing, to Medical Advances Institute (MAI), an Ohio corporation not for profit, to support this organization's development of a computerized peer review system. The recovery of funds advanced to MAI was generally dependent upon the successful marketing of the system. MAI terminated all operations in April 1980 without any sale of the computerized peer review system. As a result, the Association charged to the Government Relations Department in 1979, the expense of writing off the receivable from MAI.

4. **Pension Plan:**
The Association maintains a trusteed noncontributory pension plan for its eligible employees. The funding of the pension plan is through employer payments.

The actuarial cost method used in determining the valuation of funding is the entry-age-normal with frozen-initial-liability method.

The total cost of the plan charged to operations in 1980 was $73,733, which includes amortization of past service costs over approximately a forty-year period.

A comparison of accumulated plan benefits and plan net assets at December 31, 1980 is as follows:

	1980	1979
Actuarial present value of accumulated plan benefits	$772,534	$728,760
Market value of plan assets available for benefits	$708,115	$634,491

The assumed investment rate of return used in determining the actuarial present value of accumulated plan benefits was 6.5% for both 1980 and 1979.

5. **Leases:**
The minimum rental commitments of the Association under all noncancelable leases were as follows at December 31, 1980:

	1981	1982	1983	1984
Equipment and other	$25,592			
Automobiles	40,370	$36,454	$14,358	$280
	$65,962	$36,454	$14,358	$280

Rental expense under these and similar leases aggregated $74,617 during 1980 and $42,464 during 1979.

6. **Investment in Real Estate:**
During December 1980, OSMA purchased land and building located at 622 South High Street. The purchase price for the property was $85,000 payable in two equal installments of $42,500, with the first installment due December 1980 and the second installment due on January 15, 1981. The Association's Council approved the formation of a corporation to be known as 622 South High Street, Inc., which Corporation shall have as its main purpose the ownership and management of the property.

7. **Ohio State Medical Journal:**
The income and expenses applicable to the operations of "Ohio State Medical Journal" are as follows:

	1980	1979
Income:		
Advertising (net of commissions of $21,204 in 1980 and $28,304 in 1979 and cash discounts of $1,458 in 1980 and $1,830 in 1979)	$110,732	$118,998
Subscriptions received from nonmembers	8,485	5,946
Other	157	11,930
Membership subscriptions, allocated at $9.32 for 1980 and $5.90 for 1979, per dues-paying member (included in membership dues income on the Statement of Operations and		

Undesignated Net Worth)	102,883	61,307
	222,257	198,181
Expenses:		
Salaries, pension costs, payroll taxes and other employee benefits	85,567	81,385
Printing, postage, stationery, supplies, illustrations, engravings and consulting services	179,017	148,472
Building expenses, depreciation and other	9,205	22,620
	273,789	252,477
Excess of expenses over income, Ohio State Medical Journal	$ 51,532	$ 54,296

8. **Investment — Physicians Insurance Company of Ohio:**
The Association owns 100% of the Class B common stock of Physicians Insurance Company of Ohio (PICO). PICO has two classes of common stock, Class A and Class B. Each Class of stock has equal rights on a per share basis to participate in dividends and other types of distributions, whether from earnings or in the nature of dividends. The Association received $3,450 dividend income in 1980 and $2,500 in 1979, which are included in other income in the accompanying financial statements. Each Class A share is entitled to one vote and each Class B share is entitled to 100 votes.

   By virtue of its ownership of 100% of the outstanding Class B shares (10,000 shares), the Association is entitled to 1,000,000 votes. At December 31, 1980, the Class A shareholders owned 849,002 shares of Class A stock. Accordingly, at December 31, 1980, the Association was entitled to exercise 54.08% of the voting power of PICO. When the total authorized Class A shares (2,000,000) and Class B shares (16,667) have been sold, the Class A shareholders will have 55% of the voting control over PICO.

   Physicians Insurance Company of Ohio had a total stockholders' equity of $12,064,176 at December 31, 1980 and $10,392,713 at December 31, 1979. The Association's equity in PICO totaled $140,444 at December 31, 1980 and $120,592 at December 31, 1979.

9. **Insurance Holding Company System:**
The insurance holding company system presently consists of two affiliated persons, the Ohio State Medical Association (OSMA) and Physicians Insurance Company of Ohio (PICO).

   OSMA controls PICO by virtue of its ownership of 10,000 shares of Class B common stock of PICO, comprising 100% of such outstanding shares of stock (see Note 8).

10. **Exemption — Federal Taxes on Income:**
The Ohio State Medical Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code.

11. **Restricted Funds for Designated Purposes:**
In 1980, the Council of the Ohio State Medical Association authorized funds to be restricted for designated purposes. The funds represent cash that has been designated for the following purposes:

Capital Improvements	$111,816
Data Processing	45,499
Malpractice Research Fund	67,496
Staff Development	80,000
	$304,811

SUPPLEMENTARY FINANCIAL DATA

Our report on our examinations appears on page 1. These examinations were made primarily for the purpose of rendering an opinion on the basic financial statements, taken as a whole, shown on pages 2 to 9 of this report. The other data included in this report on page 11, although not considered necessary for a fair presentation of the financial statements, is presented primarily for supplemental analysis purposes. This additional information has been subjected to the audit procedures applied in the examinations of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

March 17, 1981 *Coopers & Lybrand*

New heights reached for hypertension victims

A new drug for high blood pressure that has significant advantages over other anti-hypertensives recently received approval from the Food and Drug Administration.

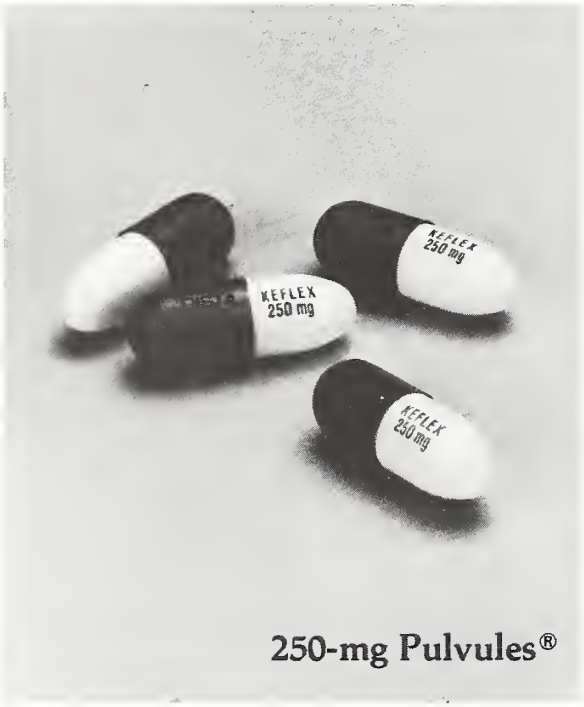
Tenormin (atenolol) is the most advanced of a class of drugs called beta blockers. It combines a simple one-tablet-a-day dosage with cardioselectivity. The drug acts primarily on the heart, resulting in few side effects and is therefore preferable for a larger number of hypertensives, especially those who suffer from asthma or other bronchospastic diseases.

Tenormin's once-daily dosage is one of its biggest benefits because it simplifies prescribing. Lack of patient compliance with prescribed therapy is the number one problem among hypertensives. Although 35 million Americans suffer from hypertension, only 5 million are adequately controlling their disease through proper treatment, according to the National Heart, Lung and Blood Institute. This is often because other drugs have complicated dosage requirements, uncomfortable side effects or both.

Tenormin was introduced abroad in 1976 and is currently available in 44 countries. It is the number one selling beta blocker in Europe.

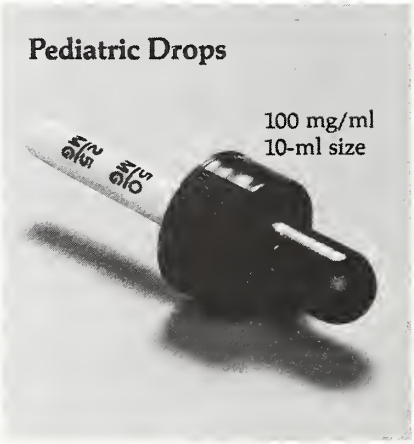
Studies abroad have also demonstrated that Tenormin reduces the number of cardiac deaths when administered after myocardial infarction. (*New England Journal of Medicine* Editorial, April 2, 1981; *The Lancet*, August 9, 1980).

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At the end of a long hard day, John Ray, M.D., looks forward to some serious guitar plucking.

A Little Bit Country

By Carol W. Mullinax

A hundred years ago, at the end of a long hard day, cowboys would seek the solace of a campfire to ease the isolation and loneliness of their calling. There, with lowing cattle and a soft guitar as background, they would raise their voices in songs that helped create a home away from home.

But times being what they are, western life has suffered. Today, cowboys ride mechanical bulls and live in condominiums and Arab sheiks own the cattle. But one facet of the old life has survived. There are still people today who think a soft guitar and a song are the best end to a long hard day.

John Ray, M.D., Zanesville, counts himself among them. While the otorhinolaryngologist isn't a cowboy — traditional or urban — he still enjoys the camaraderie of a shared song.

As a guitar player and singer in the five-member Muskingum Valley Grass Band, Dr. Ray has the opportunity to relive the cowboy experience each time his band plays. The group, consisting of a mandolin, a five-string banjo, a dobro guitar, a bass and guitar, performs primarily at bluegrass music

festivals in Ohio, Kentucky and West Virginia.

Bluegrass music has won an increasing number of converts in recent years. Drawn by its toe-tapping, low-key sound (bluegrass differs from other forms of country music in that it is played with no electrical instruments), these converts flock to weekend-long festivals to soak up the music, crafts and just plain fun.

As much as Dr. Ray loves performing at these festivals, and on other occasions, he admits that the time he enjoys most comes at the end of the day, when the crowds have gone home. Performers and friends gather around a campfire to sing and play "till the wee hours of the morning." The hand-clapping, kneeslapping audiences are exhilarating, but those times by the campfire, Dr. Ray says, are the most satisfying. Like the cowboys before them, the music provides communion and fellowship.

Dr. Ray says he has always felt drawn to music. He came by his interest naturally since his mother and maternal grandfather were musical. By the age of six he managed to teach himself to play his mother's old Hawaiian guitar. Although he was exposed to all types of music, it was country music, the love-and-hate, salvation-and-damnation songs he heard on his great aunt's radio that caught his imagination.

Although he was exposed to all types of music, it was country music, the love-and-hate, salvation-and damnation songs . . . that caught his imagination.

During high school his involvement in country music led to a stint in a gospel singing group. In college, he joined a country band, played drums in both marching and concert bands and sang in choral productions. And although he never wavered from his decision to become a doctor, he still managed to pick up enough college credits for a minor in classical music.

Since bluegrass has the reputation for being a self-taught art, Dr. Ray's classical background probably sets him apart from many of his musical contemporaries. But if that's true, he doesn't let it bother him. He says his attitude is best summed up by a country music professional, who, years ago, was asked by a hot shot reporter if he could read music. "Yes," the performer replied, "but I don't let it slow me down."

It doesn't slow Dr. Ray down either. Through the years he has expanded his horizons from merely playing music to writing it — both words and music. He says his songwriting ability "runs hot and cold. I may come up with two or three songs in a couple of days and then not do anything more along that avenue for a few months or a year or two."

He has a few songs right now he feels may have a shot at the big time and is currently in the process of copywriting and promoting them. His goal: to see one of his songs gain a



Dr. John Ray (foreground) leads the five-member Muskingum Valley Grass Band in a medley of foot-stomping tunes.

nationwide reputation by being performed by a country star.

Dr. Ray modestly disavows any dreams of becoming a star himself. "I'm not good enough," he claims. Besides, "Unless you hit it big, you probably couldn't make a living at it."

Right now he is content to play for his own enjoyment, and the "change of pace" it provides. With his busy schedule, it is probably just what the doctor ordered. Besides his private practice, he is on the OSMA's Legislative and Health Planning Committees, on the board of the Ohio Medical Political Action Committee (OMPAC), Chairman of the Muskingum County Medical Society's Legislative Committee, Chairman of Surgery at Bethesda Hospital in Zanesville, and Clinical Assistant Professor of Otorhinolaryngology at Ohio State University. All of this in addition to an interest in photography and raising roses.

Dr. Ray admits that his schedule makes life "a little hectic" at times, but he says, music gives him a "release" he can't find anywhere else. And he is elated that his daughters feel the same way. Nancy, 17, and Christy, 14, both show signs of musically following in their father's footsteps.

He says his songwriting runs "hot and cold" . . . But his goal is to see one of his songs gain a nationwide reputation

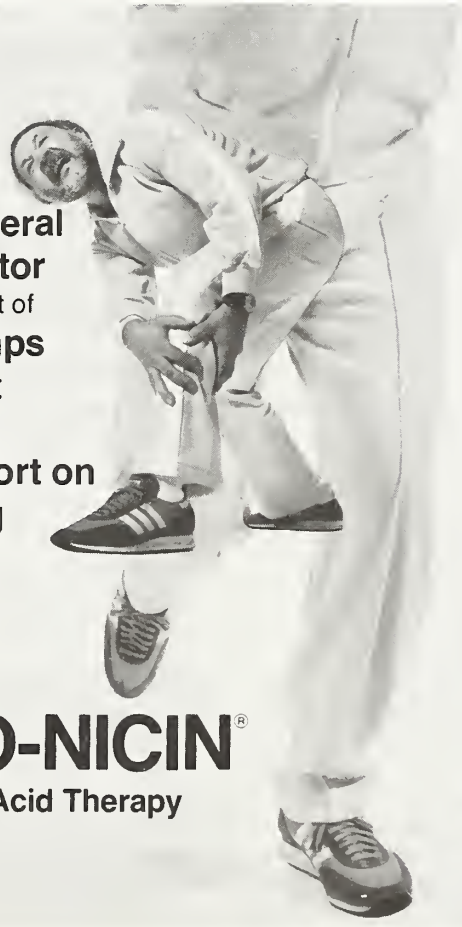
So never mind that cowboys may be heading for their last round-up. Their musical heritage has been a part of the Ray family's musical heritage for some time . . . and it looks like it will continue to be so, for a long, long time to come.

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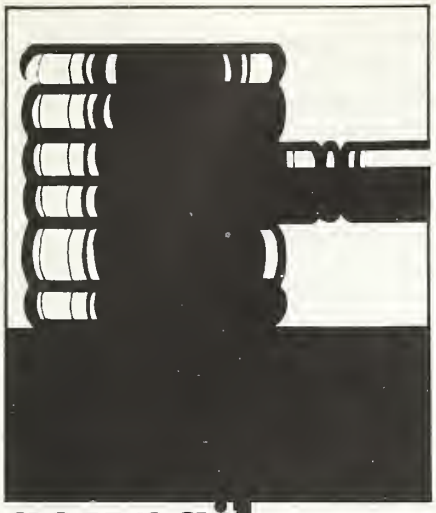
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council proceedings

PROCEEDINGS OF THE COUNCIL

July 18, 1981

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, July 18, 1981, at the OSMA Headquarters, 600 S. High Street, Columbus, Ohio.

Those present were: Stewart B. Dunsker, M.D., Cincinnati; C. Douglass Ford, M.D., Toledo; Robert G. Thomas, M.D., Elyria; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; Benjamin H. Reed, M.D., Delta; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; Joseph L. Kloss, M.D., Akron; John H. Budd, M.D., Cleveland; Oscar W. Clarke, M.D., Gallipolis; John H. Ackerman, M.D., Director, ODH, Columbus; James E. Pohlman, Esq., Columbus; Richard Ruppert, M.D., President, MCOT, Toledo.

Those present from the OSMA Staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Rebecca J. Doll; Robert E. Holcomb; Gail E. Dodson; Richard A. Ayish; Carol W. Mullinax; David W. Pennington; Eric Burkland; Jennifer M. O'Brien.

Announcements by President Dunsker

Dr. Dunsker announced the conclusion of the term of Dr. Carl Spragg on the Primary Care Advisory Committee of the Ohio Board of Regents and the appointment of Dr. John E. Albers to succeed him.

The President presented to Mr. Page an "Award of Merit" from the American Medical Association for his service as a member of the AAMSE Advisory Committee to the Executive Vice President of the AMA from 1974-1981.

Dr. Dunsker told the Council that he had met with Dr. Thomas Helmrath, Vice Chancellor of Health Affairs, of the Ohio Board of Regents on June 25, and that Dr. Helmrath will visit with the Council on September 12.

He stated that Mrs. Lee Vesper and Mrs. Richard Feezel will represent the Auxiliary on the OSMA Committee on State Legislation and that Mrs. H. William Porterfield will serve on the Committee on Communications.

According to the President, Dr. Thomas will write an instruction booklet for Reference Committees of the House of Delegates and Dr. Reamy will develop pamphlets concerning duties and responsibilities of Councilors and for new delegates and alternates to the Ohio House of Delegates.

Administration

The minutes of the May 2, 1981 meeting of the Council **were approved.**

Mr. Page presented the report of the Executive Director.

Financial and Membership Department

Treasurer's Report — Dr. Barr presented the report of the treasurer, pointing out that there is $1,890,541.94 in the Cost Management Account with an estimated annual yield of 15.39%. The report **was accepted.**

Commmittee on Auditing and Appropriations — Dr. Pfahl presented the July 17, 1981 minutes of the Committee on Auditing and Appropriations.

The Council **approved** the committee's recommendation that the OSMA proceed with the implementation of "tape to tape" entry of Medicaid claims.

Dr. Diller disclosed to the Council that his reason for abstaining from the vote is that he established the Cards, Inc. firm 18 years ago and has substantial financial interest therein.

A proposal from Cards, Inc. to format "tape to tape" entry for other carriers, such as Blue Shield, at a cost of $15,000 **was approved** with high priority assigned. (Dr. Diller abstaining, Dr. Kloss and Dr. Yut dissenting.)

The Council **approved** the recommendation of the Committee that the 1980 audit, by Cooper and Lybrand, be approved.

A recommendation that Porter, Wright, Morris and Arthur, OSMA Legal Counsel, be paid a monthly retainer against quarterly billings for legal services **was approved.**

A reimbursement of $1,376.99 to the Mahoning County Medical Society involving legal fees for the fourth quarter of 1980 and the first quarter of 1981 **was approved** contingent upon legal counsel's report of the status of the suit.

A proposal to change the design of the "fiftieth-year" award was referred back to the committee.

A recommendation that the OSMA computer system be upgraded from a Data General CS-40 to a CS-70 at a cost of $15,000 **was approved.**

Dr. Diller was asked by the President to serve as a subcommittee of the Committee on Auditing and Appropriations to evaluate long-term computer needs.

A recommendation that the OSMA file for the necessary waiver of exclusion from ERISA to borrow funds from the Pension Fund **was approved.**

The minutes as a whole **were approved.**

Membership Statistics — Mrs. Wisse presented statistics which indicated gains over last year in both OSMA and AMA membership.

Department of Education & Meeting Management

Committee on Art and Culture — Ms. Mullinax presented the April 18, 1981 minutes of the Committee on Art and Culture and they were received for information.

Tele-Research/Profesco — Mr. Campbell reported that the Tele-Research/Profesco program is being implemented and information is being circulated to OSMA members.

1981 House Resolutions — The Council approved referral of 1981 House of Delegates resolutions as follows:

Sub. Res. 1-81 to amend the OSMA Constitution and Bylaws to Create a Medical Student Section and to Provide for the Selection of Representatives of the Medical Student Section to the House of Delegates. *Administration for Constitution and Bylaws change*

Am. Res. 3-81 Organization Structure of the OSMA. *President and the Council*

Res. 9-81 Privilege of the Floor of the House for Past Councilors. *Administration for Constitution and Bylaws change*

Am. Res. 12-81 Ohio State Medical Association Annual Meeting. *Department of Education and Meeting Management*

Sub. Res. 15-81 Women in Medicine. *Membership Committee through the Council*

Res. 16-81 Comprehensive Placement Service. *The Council*

Sub. Res. 19-81 Federal Regionalism. *Legislative Dept.*

Res. 20-81 Special Commendation to the OSMA Delegation to the AMA. *OSMA Delegation to AMA*

Res. 22-81 Continued Support by OSMA and County Societies of the AAMA-OSS. *The Council*

Am. Res. 23-81 Reconvene Task Force on Professional Liability. *Task Force on Professional Liability*

Am. Res. 29-81 The Right of a Hospitalized Patient to Choose His Attending or Consulting Physician. *Was submitted to AMA House of Delegates*

Res. 30-81 Amendment Process of Medical Staff Bylaws. *The Council*

Res. 31-81 Organized Medicine Participation with Business Leaders. *Depts. of Communications & Field Service*

Sub. Res. 34-81 P.S.R.O. *Dept. of Government Relations*

Am. Res. 42-81 Opposition to Present Attempts to Change the Requirements for a Medical Certificate to Practice Medicine in Ohio. *Legislative Dept.*

Am. Res. 45-81 Welfare Payment Inequities. *Depts. of Govt. Relations & Legislative*

Am. Res. 47-81 Manpower. *Health Education Dept.*

Res. 49-81 Abolition of Mandatory Premarital Serology Testing. *Legislative Dept.*

Res. 50-81 "PAP SMEAR" LAW. *Legislative Dept.*

Res. 51-81 Resolution to Teach Bio-Ethics in Ohio Medical Schools. *Judicial and Professional Relations Committee*

Res. 52-81 Comprehensive Health Education in Ohio Schools. *Health Education Department*

Res. 53-81 Confidentiality of Quality Assurance Program Information. *Govt. Relations Dept. & Legislative Dept. to write AMA Delegation*

Res. 54-81 Voluntary Health Planning at the Local Level. *Govt. Relations Dept.*

Am. Sub. Res. 58-81 Direct Membership in AMA. *AMA Delegation & Committee on Membership*

Res. 60-81 Hospital Malpractice Insurance. *AMA Delegation*

Am. Res. 61-81 Resolution on FTC. *Was sent to AMA Delegation*

Further Action on 1981 Resolutions — Dr. Albers was named Chairman of the Committee on OSMA Structure called for in Res. 3-81. Each Councilor was asked to submit the name of a member from his district to serve with Dr. Albers.

Res. 16-81 was referred by the President to Dr. Diller's Subcommittee of the Committee on Auditing and Appropriations.

Res. 30-81 was referred to legal counsel.

Department of Government Medical Care

Committee on Health Planning — Mr. Pennington presented the July 8, 1981 minutes of the Joint Health Planning Committees of OSMA-Ohio Hospital Association-Ohio Osteopathic Association, and of the OSMA Committee on Health Planning of the same date.

The Council **approved** the "Statement of Purpose" and the "Objectives" developed by the Joint Committee.

The Council **approved** the OSMA Committee on Health Planning minutes, including the recognition of the emergence of business coalitions and the necessity to obtain appropriate representation by physicians for positive influence on health-related matters.

Committee on Professional Peer Review — Dr. Ford presented the July 1, 1981 minutes of the Ad Hoc Committee on Professional Peer Review. He submitted a document for consideration and proposed that the Committee be discharged.

The document **was approved** (Dr. Yut dissenting) and the Ad Hoc Committee was discharged.

The Council voted that an appropriate committee be appointed by the President to continue the work on Professional Peer Review.

Committee on Membership — Mr. Gillen presented the minutes of the Committee on Membership. The Council **approved** the creation of a Liaison Committee for implementation of the Student Membership Section. The minutes **were approved.**

Committee on Cost Effectiveness — The minutes of the May 1, 1981 meeting of the Committee on Cost Effectiveness were received.

Committee to Explore Negotiations Process — Mr. Gillen presented minutes of the June 8, June 9 and June 27 meetings of the Committee to Explore Negotiations Process.

The Council **adopted** the following policy on Negotiations:

"Negotiations is a viable, ongoing activity of the Association's staff and the various ad hoc committees.

It is not necessary to establish a Department of Negotiations within the OSMA structure or to appoint a special committee that would negotiate on behalf of members.

It is recommended that an Advisory Committee on Negotiations and Mediation Process be appointed with the following purposes:

1. Develop guidelines for staff in their negotiating activities.
2. Advise and assist as needed.
3. Increase awareness of the negotiation process at state and local levels.
4. Monitor and advise on trends.
5. Maintain and review a catalog of

problems where negotiations have been or are required."

The Ad Hoc Committee was discharged.

The minutes as a whole **were approved.**

Ad Hoc Committee on Incentives/Disincentives — The minutes of the May 19, June 27 and July 17 meetings of the Ad Hoc Committee on Incentives/Disincentives were presented by Dr. Abromowitz and they were received for information. It was indicated that a comprehensive report would be presented by the Committee at the September meeting of the Council.

Department of Organization Services

American Medical Association — Dr. Clarke presented his report on the June annual meeting of the American Medical Association.

The Council studied a proposal from Dr. H. William Porterfield concerning representation through specialty society delegates at the AMA. The President announced that he would appoint a committee to review the matter and to report to the Council in September.

Department of Health Education

Committee on Health Manpower — Mr. Clinger presented the minutes of the April 15, 1981 meeting of the Committee on Health Manpower.

A recommendation for a Liaison Committee with the Ohio Association of Physicians' Assistants **was approved.**

The Council, on recommendation of the Committee, reaffirmed its policy of active opposition to institutional employment of physicians' assistants.

The minutes as a whole **were approved.**

OSMA/ONA Liaison Committee — Mr. Clinger presented the minutes of the June 10, 1981 meeting of the OSMA/ONA Liaison Committee.

The Council asked that the anecdotes and vignettes discussed in the minutes be accepted for information, and no further action be taken on them.

Department of Federal & State Legislation

Federal Legislation — Mr. Mulgrew described the developments in Washington with regard to the health aspects of the Reagan budget.

State Legislation:

Joint Underwriting Association — Mr. Ayish reviewed concerns with regard to the Joint Underwriting Association.

The Council voted **to rescind** the previous policy on the JUA and to adopt the following concepts for the guidance of the State Legislative Department:

1. The immediate return of the remaining monies in the SRF to those physicians and hospitals that have paid charges, surcharges and premium increments into the fund;

2. The protection of all potential liabilities of JUA policyholders, regarding both claims-made policies and reporting endorsements;

3. The return to JUA policyholders of any "excess funds" in the JUA, such "excess" arising from premium overcharges paid into the JUA by its policyholders;

4. The maintenance of the JUA structure, with appropriate modifications (eg, repeal of the statutorily mandated Stabilization Reserve Fund) in the event that the future malpractice climate necessitates the reactivation of a modified JUA;

5. An equal opportunity for the participation of the Physicians Insurance Company of Ohio in any competitive bidding for the JUA business which might take place.

Mr. Ayish discussed the Medicaid Budget, Hospital Licensure, Certificate of Need, sunset provisions, child restraint bill, determination of death, team physicians immunity and abortion informed consent.

Mr. Burkland reviewed state medical board legislation.

Committee on State Legislation — Dr. Payne presented the minutes of the June 24, 1981 meeting of the Committee on State Legislation.

With regard to **House Bill 565,** to establish a program for Ohio State Medical Board approval of foreign medical schools, the Council voted a posture of "no position" but authorized provision of technical assistance.

Other matters presented were:

House Bill 469: The Council accepted the Committee's recommendations with regard to H.B. 469, Certificate of Need legislation, involving the maintenance of the sunset provision in the bill which would end the state statute when federal legislation is repealed or the program is no longer funded. The Council endorsed support of the concept of local health planning without federal intervention.

Senate Bill 308: "Health Planning," to track Ohio's health planning and Certificate of Need legislation with changes in federal statutes and rules is **"no position."**

House Bill 137: "Death with Dignity." The Council voted **"no position,"** but provisions of technical assistance.

House Bill 574: Dimethyl Sulfoxide (DMSO) Sales. To add DMSO to list of drugs exempt from FDA and state director of agriculture approval.

The Council supported the Committee's recommendation for a posture of **"no position."**

Senate Bill 365: Mental Outpatient Coverage for Alcoholism, requires that certain insurance contracts offer outpatient coverage for mental and emotional disorders and alcoholism treatment; **"no position"** but technical assistance.

Senate Bill 336: Alcoholism Coverage Sunset Extension. **Vigorously oppose.**

House Bill 452: "Good Faith Effort," eliminating "good faith effort" mandated in H.B. 448.

Referred to Ad Hoc Committee on Incentives/Disincentives.

Report as a whole **was adopted.**

OMPAC — Dr. Dunsker discussed a letter from H. William Porterfield, M.D., Chairman of the Board of Directors of the Ohio Medical Political Action Committee.

Department of Communications

Ms. Mullinax reported on OSMA public service announcements and that all but one (1) of thirty (30) television stations stated that they are using the

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spot announcements and wanted them continued.

Ohio newspapers and television and radio stations have requested on a ten (10) to one (1) basis to continue to receive news releases based on *Synergy* articles.

Ms. Doll requested a 10% increase in national advertising rates for the Ohio State Medical Journal and the request **was granted.**

Department of Field Service

Mr. Holcomb presented proposed bylaws for the Medical Student Section. The Bylaws **were approved.**

Councilor Reports

The Councilors reported on the activities in their respective districts.

Constitution and Bylaws Amendments

Proposed amendments to the Constitution and Bylaws of the Cleveland Academy of Medicine **were approved.**

Legal Counsel Report

Mr. Pohlman reported on pending litigation of interest to the Councilors and was authorized to develop for the next meeting of the Council an analysis of the recent developments in the law with regard to fee review activities of state and local medical societies.

Ohio Director of Health

Dr. Ackerman discussed the effect of federal and state budget cuts on the operations of the Ohio Director of Health.

He announced the appointment of Dr. A. Robert Davies, Dayton, to the Ohio Public Health Council.

He reviewed the increased incidents of wildlife rabies and Rocky Mountain Spotted Fever throughout Ohio.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

PD-400-JA-0146-P-1 (1-81)

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ANUSOL-HC® CREAM
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Caution: Federal law prohibits dispensing without prescription.
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Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
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Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
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Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
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Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
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Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
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Store between 59°-86°F (15°-30°C).
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THE RUPERT B. TURNBULL, JR., M.D. SYMPOSIUM: November 20-21; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: $170, $85 for residents; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

MANAGEMENT OF THE ARTHRITIC HIP: November 12-14; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 15 credit hours; fee: $210, $105 for residents; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

CANCER AND THE PRIMARY CARE PHYSICIAN: EARLY DIAGNOSIS AND SCREENING: November 4; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: $60, $30 for residents; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

GERIATRIC CARDIOLOGY: September 16; Rhodes Hall Auditorium, Ohio State University, 460 W. Tenth Ave., Columbus; sponsor: Ohio State University College of Medicine; 6.5 credit hours; fee: $45, $30 Nurses and other professionals; contact: Center For CME, A352 Starling Loving, 320 W. Tenth Ave., Columbus 43210, phone: 614/422-4985.

UPDATE IN RHEUMATOLOGY: September 16; Lutheran Medical Center, School of Nursing Auditorium, 2609 Franklin Blvd., Cleveland; sponsor: Lutheran Medical Center Foundation; 6 credit hours; fee: $50; no fee for residents and interns; contact: Mrs. B. Seidenwand, Office of CME, 2609 Franklin Blvd., Cleveland 44113, phone: 216/696-4300, ext. 329.

CARDIOPULMONARY BYPASS - CURRENT PERSPECTIVES: October 3; Jewish Hospital, Louisville, Ky; sponsor: Louisville Area Continuing Medical Education Consortium; 6.5 credit hours; contact: Sarah Kelly, Heart Institute of Kentucky, 217 E. Chestnut St., Louisville 40202, phone: 502/587-4768.

GASTROENTEROLOGY UPDATE - 1981: November 18-19; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 12 credit hours; fee: $120, $60 for residents; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

Free booklet available for help in medical transport

• Complimentary copies of *Air Ambulance Guidelines* can be obtained by writing General Service Division, National Highway Traffic Safety Administration, 400 Seventh St., S.W., Washington, D.C. 20590. The Guidelines attempt to provide both physician and air ambulance operators with medical factors to consider when planning air transportation of the seriously ill or injured.

Obituaries

JOHN L. CARROLL, M.D., Sandusky; Loyola University Stritch School of Medicine, Maywood, 1930; age 77; died June 6, 1981.

DAVID A. CHAMBERS, M.D., Cleveland; Case Western Reserve University School of Medicine, 1927; age 79; died July 4, 1981; member OSMA and AMA.

REUBEN A. EYESTONE, M.D., Gibsonburg; Ohio State University College of Medicine, 1929; age 80; died May 28, 1981; member OSMA and AMA.

FRANCIS O. FRY, M.D., Sandusky; Rush Medical College, Chicago, 1938; member OSMA and AMA.

FRANK J. GRABILL, M.D., Chillicothe; Case Western Reserve University School of Medicine, 1943; age 68; died June 29, 1981; member OSMA.

MARY EVANS GRAHAM, M.D., Zanesville; Medical College of Pennsylvania, 1920; age 86; died June, 1981; member OSMA and AMA.

CHARLES U. HAUSER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1937; age 70; died June 22, 1981; member OSMA and AMA.

WILLIAM CARL HUEBENER, M.D., Cincinnati; Eberhard-Karls University, Tubingen, Germany, 1921; age 88; died June 12, 1981; member OSMA and AMA.

HENRY E. KLEINHENZ, M.D., Lorain; Case Western Reserve University School of Medicine, 1943; age 62; died May 31, 1981; member OSMA and AMA.

JUSTIN E. McCARTHY, M.D., Cincinnati; Creighton University School of Medicine, Omaha, 1927; age 79; died June 12, 1981; member OSMA and AMA.

NEIL MILLIKIN, M.D., Hamilton; Harvard Medical School, Boston, 1925; age 80; died June 9, 1981; member OSMA and AMA.

C. CLARKSON PAYNE, M.D., Dayton; University of Cincinnati College of Medicine, 1920; age 88; died June 17, 1981; member OSMA and AMA.

VINCENT SANTANGELO, M.D., Columbus; Philadelphia College of Osteopathic Medicine, Philadelphia, 1962; age 49; died July 20, 1981; member OSMA.

JACK M. SCHECHTER, M.D., Toledo; Temple University School of Medicine, 1946; age 58; died June 25, 1981; member OSMA and AMA.

CARL I. SNIDER, M.D., Cleveland; Eclectic Medical College, Cincinnati, 1936; age 72; died May 30, 1981; member OSMA and AMA.

DONALD R. SPERRY, M.D., Newark; Ohio State University College of Medicine, 1935; age 71; died June 1, 1981; member OSMA and AMA.

RICHARD L. TAYLOR, M.D., Cleveland; University of Michigan Medical School, Ann Arbor, 1943; age 64; died November 7, 1980; member OSMA and AMA.

HARRY WAIN, M.D., Mansfield; Loyola University Stritch School of Medicine, 1935; age 74; died June 24, 1981; member OSMA and AMA.

DAVID T. WILLIAMS, M.D., Newark; University of Maryland School of Medicine, Baltimore, 1914; age 92; died June 21, 1981; member OSMA and AMA.

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S. M. Chou
Seth W. Eisengart
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Sivaramakrvshnan Nair
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C. Robert Schmidt
Michael Spero
Frank J. Thomas
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DARKE
Michelle Uhl, Greenville

HAMILTON (Cincinnati unless noted)
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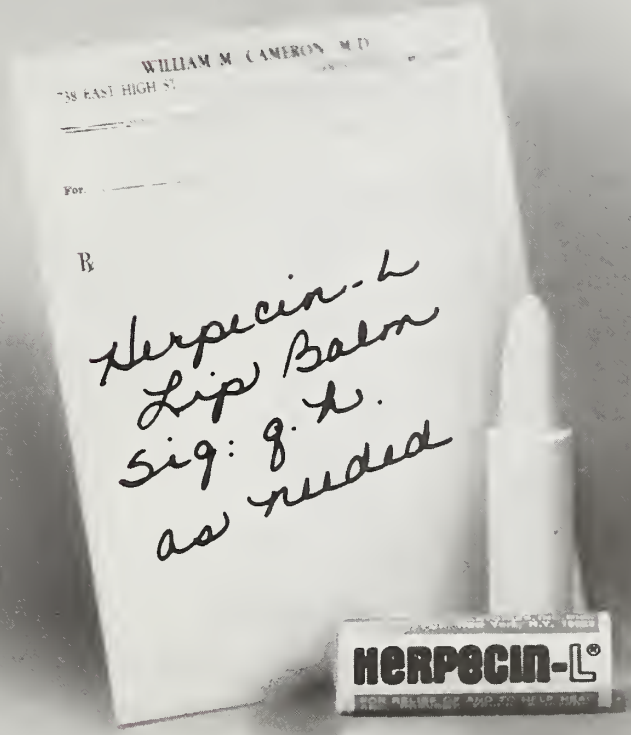
LUCAS (Toledo unless noted)
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Thomas H. Kuhn
Lewis B. Morrow

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ANESTHESIOLOGIST: board certified seeking group practice or fee for service. Please reply to Box No. 914, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

CALIFORNIA - Director Positions Available

Emergency medicine physicians needed for rural northern California areas. Excellent opportunity to join growing partnership of career emergency physicians. Emergency medical residency, board certification or at least two years experience required. Excellent benefit package and profit sharing. Contact Judy Neal, California Emergency Physicians, 440 Grand Ave., Suite 500, Oakland, CA 94610, (415) 832-6400.

EMERGENCY DEPARTMENT PHYSICIAN - CLEVELAND, OHIO: New emergency group desires career-minded emergency physicians. Opportunity is unlimited. Superior starting salary; vocational and educational leave; malpractice and hospital insurances paid; other fringe benefits available. Since we are a new group without prior commitments, full participation in the group's corporate structure is anticipated for the correct physician within one year. Call for interview: Mitchell W. Leventhal, M.D., President, Medical Emergency Services, Inc., phone: 216/888-4411 or 831-4095.

EMERGENCY MEDICINE: Directorships and clinical opportunities available at various hospitals throughout central Ohio. Modern facilities with excellent specialty support. Varying compensation based on patient volumes. Paid malpractice insurance, flexible scheduling, bonus for CME and reimbursement of state licensure. For details, send credentials in confidence to Jim Ginter, 3720-B Olentangy River Road, Whetstone Medical Center, Columbus, Ohio 43214; or call collect, 614-457-9761.

EMERGENCY MEDICINE: Assistant directorship and emergency physician positions available in a teaching institution in Northwestern Ohio. EMS and ACLS involvement preferred. Remuneration 90-100K including fringes. Respond with CV to Edwin Pont, M.D., C.S. No. 10008, Hospital Support Center, Toledo, Ohio 43699; or call Sue Masterson (800) 327-0413.

EMERGENCY MEDICINE: Clinical and Directorship positions available in the Northeastern portion of Ohio. Excellent compensation, paid malpractice insurance. For additional information contact Jim Ginter, 3720-B Olentangy River Road, Whetstone Medical Center, Columbus, Ohio 43214 or call collect 614-457-9761.

EMERGENCY MEDICINE: Clinical positions available in moderate volume emergency department located just one hour from Cleveland. Excellent income, flexible scheduling and liability insurance provided. For details, send credentials in confidence to Jim Ginter, 3720-B Olentangy River Road, Whetstone Medical Center, Columbus, OH 43214; or call collect 614-471-4981.

EMERGENCY PHYSICIANS - dynamic group of career-oriented emergency department professionals has limited openings for Ohio-licensed emergency physicians in a teaching institution. EMS and ACLS involvement perferred. Attractive compensation and fringes. Respond with CV to Susan Masterson, Emergency Medical Services Associates, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322 (800/327-0413).

EMERGENCY MEDICINE OPPORTUNITIES AVAILABLE: Directorship and clinical positions open in modern, moderate volume emergency department located in southeastern Ohio. Fee-for-service compensation with minimum guarantee provided. Additionally, flexible scheduling with no on-call responsibilities, paid professional liability insurance, and total specialty support. For details, send credentials in confidence to Jim Ginter, 3720-B Olentangy River Road, Whetstone Medical Center, Columbus, Ohio 43214; or call collect 614-457-9761.

FULL TIME MEDICAL HOUSE PHYSICIAN POSITIONS IMMEDIATELY AVAILABLE. Prefer board eligible or board certified physicians. Hospital is a 407-bed community teaching hospital in Barberton, Ohio. Barberton is contiguous to Akron and about 35 miles from downtown Cleveland. Attractive salary and benefits. Contact: Barberton Citizens Hospital, c/o House Physician Recruitment, 155 5th Street, N.E., Barberton, Ohio 44203 (216) 745-1611.

BOARD CERTIFIED INTERNIST, 29, practicing two years, wants to relocate in Ohio. Seeks solo, group, partnership, or buy established practice. Available July 1982. Reply to Box No. 923, c/o Ohio State Medical Journal, 600 S. High St., Columbus, OH 43215.

GROUP PRACTICE IN NORTHERN OHIO has opening for general surgeon - board eligible - willing to do small amount of general practice. Small community near large metropolitan areas. Reply to Box No. 915, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

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THE Ohio STATE Medical Journal
(ISSN 0030-1124)

Features

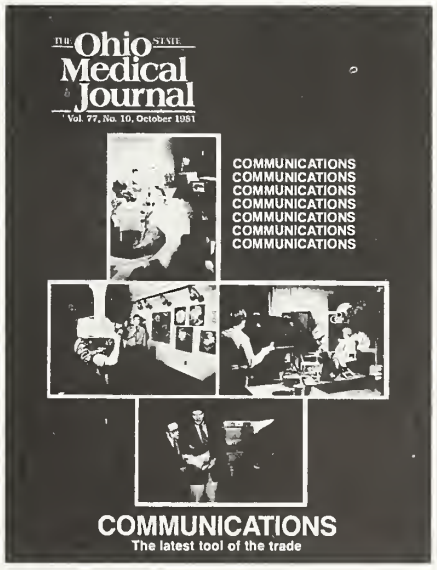
This month's issue explores the subject of communication, and how it is currently being used in the practice of medicine. The contents are divided into four sections: Physician-Patient Communication; Patient-Physician Communication; Public Appearances (physician image); and Physician-Physician Communication. Communication is a valuable tool in today's practice, and this issue not only attempts to find out why, but how best to use this latest tool.



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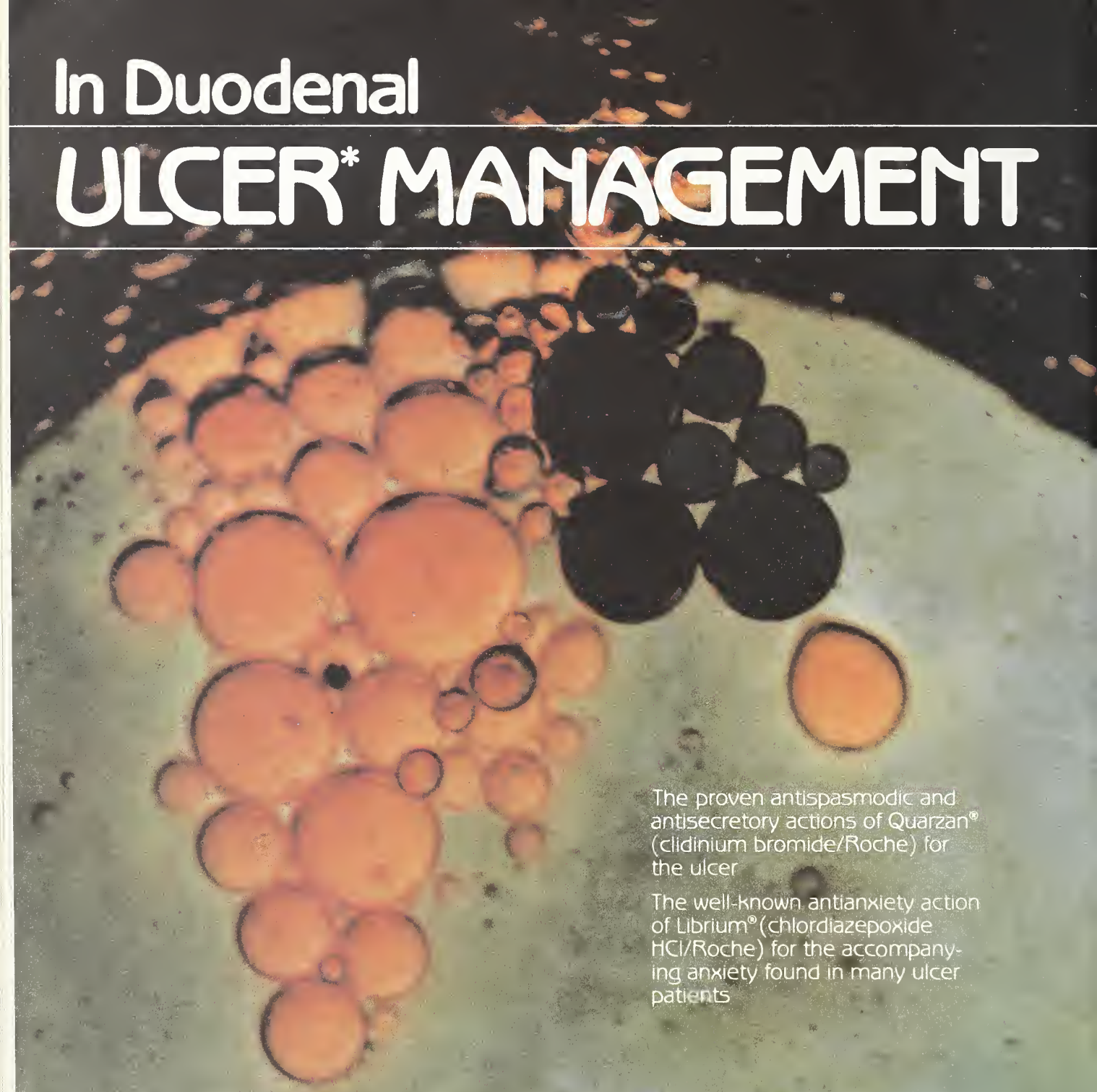
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Our Cover

Top: Victor Vermuelen, M.D., Columbus, quizzes panelists (left to right) Harold Lubin, M.D., Ann Bellisari, and Neil Baker, Ph.D. on WCMH-TV's "Doctors on Call" (photo by David Smith, WCMH-TV).
Middle: Left: Deirdre O'Connor, M.D., Toledo, chats with Paul Smith, host of the locally produced "AM Magazine" on a medical subject of interest to viewers (photo by Kathy Lewton, Academy of Medicine of Toledo).
Right: Ted Castele, M.D., Cleveland, frequently goes on location to film his brief health reports for WEWS-TV.
Bottom: Al Thielen, M.D., Cincinnati, moderator of WCPO-TV's "Call the Doctor" program, goes behind the camera to check out program notes with the show's producer, George Winters (photo by Leslie Laine, Academy of Medicine of Cincinnati).

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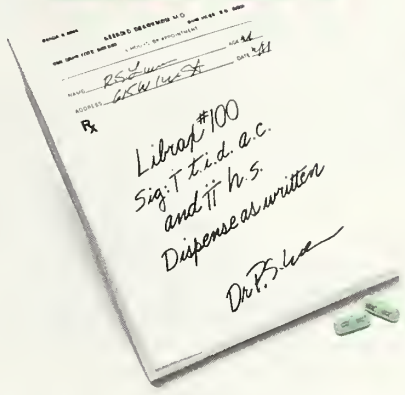
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Photograph of simulated gastric hypersecretion.

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"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema; minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Letters ...to the editor

On Teenage Pregnancies

To the Editor:

I would like to comment about the Committee Report contained on page 477 of the August 1981 edition of the *Ohio State Medical Journal*. That report states that "50-55% of Americans are opposed to abortions in any form plus an additional 20-25% oppose abortion except when the life or long-range health of the mother is involved." I think that these are highly inflated figures.

A public opinion poll conducted in Ohio by R L Associates of Princeton, New Jersey, in June 1981, indicated only 14% were opposed to abortion in all circumstances. 41% favored it in specific circumstances, while 45% felt that either it is a personal or private matter or favored it in all circumstances. Another poll conducted by the American Broadcasting Company and the Washington Post indicate that 40% of the population favored abortion on demand, 34% in most circumstances, 16% disapproved in certain circumstances, and only 10% disapproved in all circumstances.

Perhaps the figures which you have circulated indicate the wishful thinking of those who hope to deny women their reproductive freedom. The vocal minority certainly does not speak for the population at large.

Sincerely,
/s/**Alvin Langer, M.D.**
Northeastern Ohio Universities
Canton, Ohio

To the Editor:

In the article on "Teenage Pregnancies" reported in the August 1981 edition of the Ohio State Medical Journal, the author referred to public opinion on abortion but did not cite any reference for the statistics used.

Major public opinion polls, ABC/Washington Post and the Ohio Public Opinion Poll, both conducted earlier this year, reveal that 40% to 45% of the population view abortion as a personal private matter, and favor keeping it legal in all circumstances. An additional 35% to 40% believe abortion should be legal for a significant wide range of reasons. Both polls revealed a small percentage (10% to 14%) opposed abortion under all circumstances.

Although abortion is not the solution to the problems of unplanned teenage pregnancy, it is an option chosen by some, and according to majority public opinion should remain a legal option.

Education, as the author indicated, does indeed appear to be the best answer. Planned Parenthood of Stark County, responded to these problems in our community by developing a specialized Teen Education Program. In 1978, the live birth rate to teens in Stark County ranged from 1 in 4 to 1 in 5 (20% to 25%); by 1980, there was a marked decline ranging from 1 in 7 to 1 in 8 or a 12 to 13% live birth rate to teens. The success of our program in Stark County continues to depend upon a blend of contraceptive care and of effective **early** reproductive education.

We conclude that the problems of teenage pregnancy continue to abound because of the ambivalence in our society which seeks to prevent adolescent pregnancy but fears the effects of early reproductive education. Neither birth control education nor contraceptive services can await the initiation of intercourse. Timing is crucial.

Sincerely,
/s/Yvonne E. Bolitho
Planned Parenthood of Stark Co.
Canton, Ohio

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HENRY BACHMAN, M.D., McConnelsville, received the Outstanding Morgan County Senior Citizen Award. Dr. Bachman was a family physician in Malta from 1946 until his retirement in 1967. He was instrumental in helping Morgan County acquire its Health Center. Dr. Bachman is listed in Who's Who in the Midwest and has had numerous papers published on various medical subjects.

The following physicians were honored for their 50 years in medicine: **SIMON BUNIN, M.D.,** Mayfield Heights; **ROSCIUS C. DOAN, M.D.,** Miamisburg; **JACK I. JAFFA, M.D.,** Maple Heights; **ROBERT K. JONES, M.D.,** Cincinnati; **CARL A. LINCKE, M.D.,** Carrollton; **HARRY K. LYNNE, M.D.,** Jefferson; **ANDREW W. MIGLETS, M.D.,** Youngstown; **RICHARD A. PFARRER, M.D.,** Dayton; **BOYD W. TRAVIS, M.D.,** Bluffton; and **EDGAR J. WILLKE, M.D.,** Maria Stein.

The following physicians have been named to national committees of the American Academy of Pediatrics: **ANTOINETTE EATON, M.D.,** Columbus, Committee on Community Health Services; **DONALD J. FRANK, M.D.,** Cincinnati, Memorial and Endowment Fund Selection Committee; **HOMER ANDERSON, M.D.,** Columbus, Committee on Nutrition; **NORMAN GLAZER, M.D.,** Akron, Committee on Radiology; **THOMAS E. SHAFFER, M.D.,** Columbus, and **PAUL G. DYMENT, M.D.,** Cleveland, Committee on Sports Medicine; and **DONALD P. BARICH, M.D.,** Parma Heights, Provisional Committee on Practice and Ambulatory Medicine.

WILLIAM D. INGLIS, M.D., Columbus, was reelected president of the board of trustees of the Central Ohio Lung Association.

CARL A. LINCKE, M.D., Carrollton, was presented with an award by the Ohio Academy of Family Physicians for 50 years in medicine and his long service to humanity. Dr. Lincke began his practice in Carrollton in 1932.

CHARLES LONG, M.D., Warren, was appointed medical director of Hillside Hospital. Dr. Long previously was codirector of rehabilitation medicine for the Cuyahoga County Hospitals and director of rehabilitation for Highland View Hospital.

ROBERT E. REIHELD, M.D., Orrville, was awarded posthumously the Family Physician of the Year Award for his dedication and service to his community and his diligent pursuit of the principles of family practice.

ROBERT E. TSCHANTZ, M.D., Canton, was elected chairman of the Board of Trustees of Northeastern Ohio Universities College of Medicine. Dr. Tschantz, an internist, has served as president of Stark County Medical Society, Canton Academy of Medicine, Ohio State Medical Association and as chairman of the Committee on Private Practice of the American Medical Association. He has also served as president of Aultman Hospital and of the Canton Hospital Bureau.

The following were installed as officers of the Ohio Academy of Family Physicians:

JOHN E. VERHOFF, M.D., Columbus, president-elect; **W. H. WEDDINGTON, M.D.,** Columbus, vice-president; **THOMAS U. TODD, M.D.,** Cincinnati, treasurer; **TERENCE P. TORBECK, M.D.,** Dayton, speaker of house; **V. FRANKLIN COLON, M.D.,** Cincinnati, vice-speaker; **ANDREAS S. AHBEL, M.D.,** Canton, national alternate; and **KENNETH A. FREDERICK, M.D.,** Cincinnati, national delegate.

Newly elected directors were: **JOHN L. THINNES, M.D.,** Cincinnati; **JAMES T. BOWLUS, M.D.,** Jackson Center; **RICHARD W. PRESSLER, M.D.,** Cleveland; **FELIPE V. LAVAPIES, M.D.,** Tiltonsville; **G. HOWARD WOOD, M.D.,** Chillicothe; and **JOHN M. ROBINSON, M.D.,** Wooster.

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SECOND OPINION

Teenage Pregnancy and Education

By D. B. Fraatz, M.D.

The article **Teenage Pregnancy** in the August OSMA Journal concludes "education, education, and more education appears to be the best approach to this problem." While the article addresses itself to pregnancy, the epidemic of venereal diseases also belongs in the same consideration. This conclusion presumes these problems can be resolved by education, so one must assume they are, at least in part, caused by lack of same. First, I should like to ask middle-aged colleagues who grew up in the trying times of the '30s and unstable '40s when structured sex education was in short supply, how many of your high school or college classmates suffered from VD or were involved with unplanned pregnancy? At the age of 14 or 15 how many of you had no idea where babies came from?

Early in the '50s, sex education became increasingly fashionable and in ever-increasing amounts, much subsidized by federal and state funds. For years and years endless publications have shouted the need for more sex education. Fine. Is there a high school in the land that doesn't include sex education and sexuality in its curriculum? Probably a few. Check the number and variety of human sexuality courses, programs, and workshops on any college campus. The nation is inundated with learned literature on sexuality, and it grows daily. So do the problems.

Masters and Johnson are quoted as saying 10-15% of pregnant teenagers know little or nothing about reproduction! That would suggest 85-90% know a great deal and it makes no difference.

The admonition is to start sex education at even earlier ages. The reasonable logic is that 10,000 of the 600,000 teenager births were in the under 15 age group before the usual time to start such education programs. True, but the other 590,000 were over 15 and their exposure to enlightenment seems to have made no difference.

The comment is made, "Most teenagers appear to have an aversion to contraceptives." This suggests not lack of information but lack of interest.

"Perhaps before we cry for more and more education, we should consider carefully the effect of what we have and look hard at who is teaching what."

If we presume lack of education (knowledge) does not appear to be the primary root of the problems, where else can we look? Ponder for a moment the concept that during these same decades a philosophy brought forth, written about, and taught by a new breed of social planner was accepted by the public and marked a significant deviation from existing social standards. This spoke of the terrible frustrations wrought by the reactionary morality of the time, the need for fully understanding and accepting all aspects of the proffered sexuality, and the evils encountered should any of these drives, urges, or inclinations go unfulfilled for even five minutes. We were being educated indeed.

Faced with this onslaught, parents backed off imposing their moral standards lest junior be forever emotionally stunted, organized religion quickly lost its grip on behavioral direction, and the schools taught just the facts, ma'am, just the facts. *Playboy* magazine assumed the role of arbiter of public morality and the commandments are according to Hugh Hefner.

Perhaps before we cry for more and more education we should consider carefully the effect of what we have and look hard at who is teaching what. The ever-growing problems paralleling the growth of sexuality education may not be cause and effect, but there seems to be little evidence of therapeutic value. Urging an uncritical more of the same approach may lack wisdom.

First we need to step back a bit and determine just what it is we want to be. Then perhaps we can learn how to get there and who should lead the way.

D. B. Fraatz, M.D., is a member of the OSMA, an Assistant Clinical Professor of OB-GYN at Northeastern Ohio Universities, and is the Director of Medical Education at Robinson Memorial Hospital.

STATE

GOVERNOR PROPOSES TAX INCREASE LEGISLATION TO A RELUCTANT GENERAL ASSEMBLY

At the request of Governor Rhodes, Representative Myrl Shoemaker has introduced legislation imposing a new 21-month temporary tax package. House Bill 694 includes an initial 1.75 percent increase in the state sales tax, which would drop to 1 percent next July and expire at the end of the biennium a year later. The Governor also proposed a 15 percent surcharge on the corporate franchise tax for two payment periods, an increase in the beer and wine excise tax for the 21 months remaining in this biennium, and extension of the sales tax on cigarettes, for the rest of the biennium. The state is currently operating on a four-month interim budget slated to end October 31; the Governor has asked that his newly proposed tax package be approved by October 1.

In return for the new temporary taxes, the Governor promised the elimination of 3,300 state jobs through attrition by December 1982. These cutbacks will help provide the additional $1.3 billion that the Office of Budget and Management estimates will be necessary to operate Ohio at current levels.

House Speaker Vern Riffe (D-New Boston) voiced support of the Governor's tax package. Although Rep. Shoemaker, sponsor of the bill and chairman of the House Finance and Appropriations Committee has promised twice daily committee hearings on the measure, Speaker Riffe does not expect to have a floor vote on the bill before the end of September.

There will be even further delay of the bill in the Senate, where Senate President Paul Gillmor (R-Port Clinton) plans no Senate sessions until the week of October 6. Several Republican senators adamantly oppose any tax increase; others are "reluctant" to pass a tax increase while the spending cuts promised by the Governor's original budget remain shelved during the interim budget.

FEDERAL

REAGAN'S HEALTH CARE COMPETITION POLICIES THREATENED BY RISING HOSPITAL COSTS DESPITE EFFORTS BY THE VE

Statistics gathered by the American Hospital Association indicate that hospital costs in general and inpatient costs in particular have increased at a faster rate than consumer prices have increased. In April of 1981, the increase in hospital costs was 19.3 percent over hospital costs in April of 1980; during the same period, the consumer price index increased only 10 percent. Inpatient costs for the first seven months of 1981 increased at a rate of 12.6 percent annual rate compared with consumer price increases of only 9.4 percent in the same period. For July alone the increase in overall medical price index was 1.3 percent, the highest since February 1980.

These statistics represent an apparent reversal in health care cost-restraint trends begun in 1978 with the Voluntary Effort to Control Health Care Costs (VE). The VE is a coalition of hospitals, physicians, insurers, businesses, and consumers organized to present an alternative to the Carter Administration's threat of mandatory cost controls. In response to the recent escalation in health care costs, the VE's goals are to slow the rate of increase in inpatient and hospital expenditures in 1981, and to reduce it by 2 percentage points in 1982. The VE hopes that by 1983, the rate of increase will be comparable to growth of the total gross national product (GNP) which was 19.2 percent annually during the first quarter of 1981 before the adjustment for inflation.

The new statistics not only challenge the effectiveness of the VE, but could also complicate the Reagan Administration's efforts to dismantle existing regulations. The pro-competition strategy attempts to check cost increases in federal health programs by instituting incentives to encourage private insurers to develop innovative lower-cost plans.

Federal legislation to enact these proposed strategies is scheduled for introduction late in 1981, and may include proposals for cashing out medicare and giving new enrollees vouchers to purchase health insurance privately. (See Gradison proposal below.) The legislation may also limit the amount of the tax deductions employers can take for their contributions to employee health plans.

Because of the latest results in voluntary programs to restrain health care costs, many government officials believe a cost control strategy yielding more immediate savings may be necessary.

In the face of contrary health care cost statistics and limited congressional enthusiasm for deregulation, the VE continues the push to contain costs. New VE programs will raise consumer awareness of health care costs, encourage greater use of outpatient facilities, and stress preventive health measures.

GRADISON/GEPHARDT PROPOSAL ESTABLISHES "MEDICARE VOUCHER" SYSTEM

Representative Willis Gradison, Jr. (R-Ohio), and Representative Richard Gephardt (D-Missouri), have developed a proposal under which Medicare beneficiaries would receive

federal "vouchers" with which to purchase commercial health insurance or enroll in group health plans. Representative Gradison hopes for hearings in the House Ways and Means Committee Health Subcommittee, on which he serves as ranking minority member. The bill, which embraces the pro-competition health care policy supported by the Reagan Administration, will be included on a subcommittee agenda containing several other health care competition bills. The bill is currently being reviewed by the OSMA.

HEALTH CARE COMPETITION PROPOSALS TO BE HEARD IN CONGRESS

The Subcommittee on Health of the House Committee on Ways and Means will hold September hearings on legislation designed to stimulate competition in the financing and delivery of health care. Several pro-competition proposals have been introduced in the current 97th Congress. The major pieces of "pro-competitive" legislation introduced to date include: HR 850, the National Health Care Reform Act of 1981 (Gephardt, D-Missouri), S 433, the Health Incentives Reform Act of 1981 (Durenberger, R-Minnesota) and S 139, the Comprehensive Health Care Reform Act (Hatch, R-Utah). It is likely that the recently developed Gradison/Gephardt "Medicare Voucher" proposal will also be scheduled for hearings.

The bills introduced to date vary, but there are several elements common to all. The major elements which characterize the "pro-competition" bills include changes in the tax treatment, for both employers and employees, of employer contributions to health benefit plans; establishment of incentives or requirements for employers to offer employees multiple choices of health plans (subject to certain limitations with respect to coverage of services and cost-sharing, including catastrophic benefits and preventive care); and establishment of Medicare and Medicaid voucher systems under which aged, disabled and low-income persons would receive a fixed-value voucher which could be used toward the purchase of a qualified health plan.

The "National Health Care Reform Act of 1981" (HR 850) would alter the present delivery of health services. Like other pro-competition measures, the bill would use the tax laws to encourage the availability of multiple health, insurance programs to health care consumers. Unlike other proposals, the bill would not require employers to actually offer health insurance programs to their employees.

The "Health Incentives Reform Act of 1981" (S 433), would use the tax law to encourage employers with more than 100 employees to offer at least three health insurance plans to employees. Employers would be required to make equal contributions on behalf of all employees selecting a plan. Employees selecting a plan costing less than the amount of the employer's contribution would be eligible to receive the difference in cash or other benefits.

The "Comprehensive Health Care Reform Act" (S 139), is intended to stimulate health insurance competition and encourage patient participation in health care pricing decisions. S 139 was introduced in the 96th Congress as S 1590 by then Senator Schweiker (now Secretary of Health and Human Services). Current tax benefits to employers and employees in employment-based insurance would be made conditional upon the presence in the plan of certain measures designed to contain costs and make catastrophic illness and preventive care benefits available to employees and their families. Failure of an employer to comply with the specific requirements would mean loss to the employer of deduction of premium contributions, and loss to employees of the exclusion from taxable income of amounts contributed to premium by the employer. Although the bill requires large employers to offer insurance and specifies details of coverage, there is no specification in the bill as to who shall pay the premium. An employee's choice of any of the health benefit plans offered to him by his employer and his enrollment in any such plan would be entirely voluntary.

The Subcommittee on Health of the Committee on Ways and Means will hear testimony on the effectiveness of these measures in containing health care costs; the impact of the proposals on providers, insurers, employers, employees, and beneficiaries of the Medicare and Medicaid programs; and problems of implementation and administration, adverse selection, effectiveness of incentives, and adequacy of coverage.

FEDERAL RULES ON OUTPATIENT TESTS DONE IN PHYSICIAN OFFICES FINALIZED

The August 24, 1981 **Federal Register** published the Health Care Finance Administration's (HCFA) final rule establishing payment criteria for laboratory services billed by physicians, as required by Section 918 in the budget reconciliation act of 1980. The rule establishes three levels of reimbursement. First, if the laboratory test is performed by a physician, or by personnel under his supervision, it will be paid for on the basis of the reasonable charge for the service. Second, if the test is performed by an independent laboratory, but billed by a physician who identifies the laboratory and the amount the laboratory charged him, it will be paid the lesser of (a) the laboratory's reasonable charge for the service, or (b) the amount the laboratory charged the physician; plus a nominal handling fee. Third, where the physician does not identify the laboratory and the charge, payment will be based on the lowest amount at which the Medicare carrier estimates the test could have been obtained in the locality.

It is important to note that if a physician does not indicate who performed the test, or the amount charged is performed outside, carriers will estimate a "lowest amount" payment. A "lowest amount" payment is calculated by obtaining price lists for charges made to physicians from as many commercial laboratories in the area as possible, which may include laboratories in other states.

Currently, Medicaid must pay directly to the provider of services, not to the ordering physician. The new regulation changes Medicaid reimbursement to permit states to pay a physician for outside laboratory services. Payment will not exceed what would be authorized under Medicare. The federal Health and Human Services Administration is required to report to Congress within two years on the impact of the new regulation on costs to beneficiaries.

HCFA published this regulation as a final rule, with no public hearings, because "the law is explicit. . .with virtually no room for policy discretion." However, HCFA will accept "comments" on the regulation until October 23, 1981.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

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Complete literature available on request from Professional Services Dept. PML.

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by Karen S. Edwards

Decline in number of foreign medical graduates may mean physician shortage

Declining numbers of foreign medical graduates practicing in the U.S. may mean a temporary shortage of physicians in some cities and in some medical specialties, says an article in a recent issue of the *Journal of the American Medical Association*.

However, the mounting output of U.S. medical schools may fill the gap in another decade.

Foreign medical graduates, particularly the foreign-born, accounted for as much as 50 percent of the staff at many city, church and VA-operated hospitals throughout the U.S. in 1975. This ratio has since declined. If the trend continues, many urban areas, particularly New York, will have trouble filling staff vacancies, the report indicated.

While the number of foreign-born FMGs in the U.S. decreases, U.S. citizens with foreign degrees doubled between 1975 and 1979. However, most USFMGs settle in the Sun Belt, Colorado or on the West Coast, giving the Eastern cities little relief.

Specialty areas that will feel the decline of FMGs include internal medicine, general surgery, psychiatry, pediatrics, pathology, obstetrics-gynecology and family practice. While USFMGs are filling many of these vacancies, overall shortages will still exist in urban areas, they said.

Vitamin Dangers

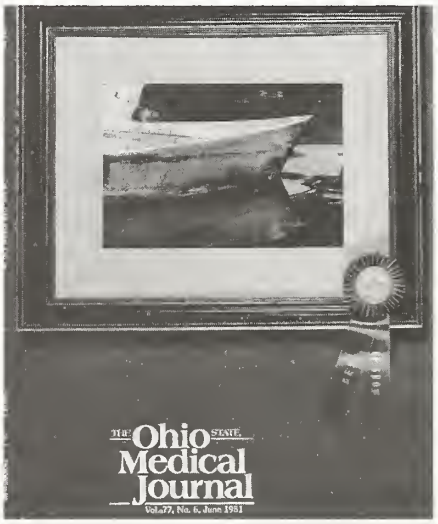
Vitamins, while admittedly expensive, have always been a harmless means of self-medication. What the body couldn't use was safely excreted — and the chances of a vitamin overdose occurring were virtually nil.

But a recent report in the *American Journal of Diseases of Children* cites not one but two cases of serious multisystem disease, associated with ingestion of excessive amounts of vitamin A and D.

The use of high-dose vitamin preparations called megavitamins are largely at fault, writes a group of pediatricians from the University of California Hospital and Clinics, where the two cases were treated. Other factors cited were "the frightening combination of a multimillion dollar health food industry; a population of consumers interested in holistic medicine; and a court decision that vitamins are not drugs, and may be marketed without FDA consent.

This situation has a dangerous potential for abuse of megavitamins and the occurrence of new diseases, the authors warn.

The OSMA's Photo Finisher



Tucked away behind an article on "Superdocs" in a recent issue of Columbus' city magazine, *Columbus Monthly*, is a display of winners of their fifth annual photo contest.

The woman who captured their "third place, amateur, color" category is the same woman who has walked away with top honors (two years in a row) in the *Ohio State Medical Journal's* photo contest — Mrs. Vera Kalnins, from Bucyrus, Ohio.

Her photo entitled "Frost" — captured one wintry afternoon in the Hocking Hills — is included in the display, and worth a look if you can get hold of a copy.

Our congratulations to Mrs. Kalnins, again — and to our own panel of judges — who seem to be able to spot a winner when they see one.

Obituaries

NOBUHISA BABA, M.D., Columbus; University of Tokyo, Tokyo, Japan, 1957; age 49; died May 7, 1981; member OSMA and AMA.

NORTON BARE, M.D., Omaha, Nebraska; University of Nebraska College of Medicine, Omaha, 1925; age 89; died April, 1981; member OSMA and AMA.

General MacArthur's staffer dies

DAVID A. CHAMBERS, M.D., Cleveland; Western Reserve University School of Medicine, 1927; age 79; died July 2, 1981; member OSMA.

RICHARD H. GOLLINGS, M.D., Sun City, Arizona; Hahnemann Medical College and Hospital, Philadelphia, 1947; age 59; died February 8, 1981; member OSMA and AMA.

ARTHUR T. HOPWOOD, M.D., Parkersburg, West Virginia; Harvard Medical School, Boston, 1926; age 84; died May 1981; member OSMA and AMA.

HOPE HYAMS, M.D., Fairfield; Ohio State University College of Medicine, 1949; age 56; died April 29, 1981; member OSMA and AMA.

JOSEPH KATZ, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1916; age 88; died January 28, 1980; member OSMA and AMA.

MILTON A. LEVINE, M.D., Portsmouth; Ohio State University College of Medicine, 1932; age 73; died July, 1981; member OSMA and AMA.

BERNARD S. MALASKY, M.D., Cleveland; Loyola University Stritch School of Medicine, Maywood, 1939; age 70; died July, 1981; member OSMA and AMA.

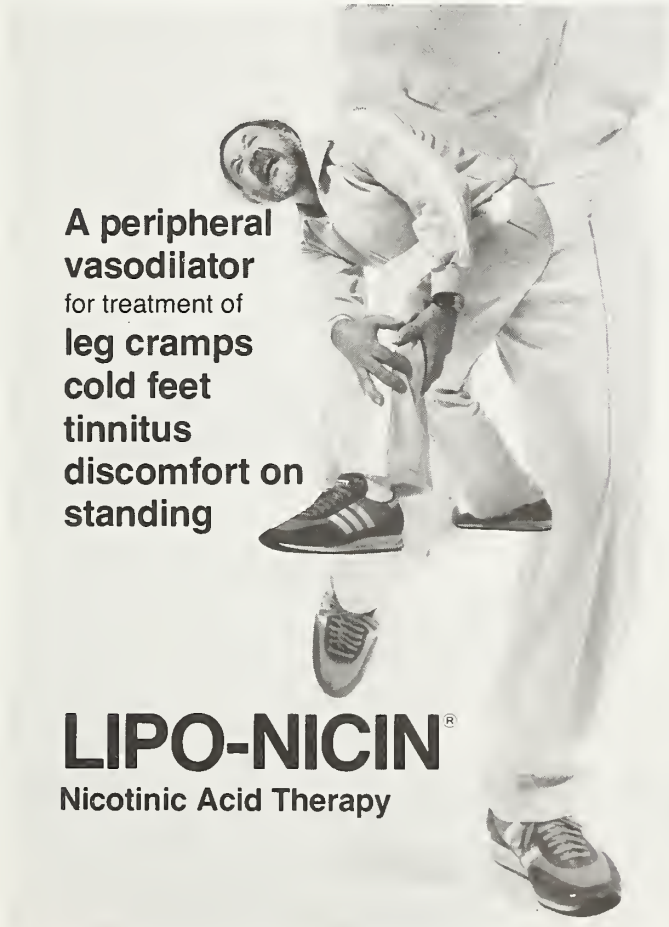
NORSUDA NEWPORT, M.D., Columbus; University of Oklahoma School of Medicine, 1935; age 74; died May 8, 1981; member OSMA and AMA.

MAITLAND PLACE, M.D., Dayton; University of Iowa College of Medicine, Iowa City, 1928; age 77; died January 13, 1981; member OSMA.

FRANKLIN SCHLUETER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1941; age 64; died May 3, 1981; member OSMA and AMA.

ERNEST D. STOKIEN, M.D., Cleveland; Case Western Reserve University School of Medicine, 1939; age 66; died April 25, 1981; member OSMA and AMA.

CLYDE S. THOMAS, M.D., Cincinnati; University of Illinois College of Medicine, 1918; age 97; died December, 1979; member OSMA and AMA.



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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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The latest tool of the trade

"What we have here is a failure to communicate."

When that line was first spoken during the movie, "Cool-Hand Luke," thousands of moviegoers were jolted right out of their plush-bottomed seats. Never before had a phrase brought home, so clearly or succinctly, the importance of communication — or what can happen when that vital link breaks down.

Certainly, the more complex our society grows the more vital that link becomes, and that seems to be especially true in the area of medicine. Not only has the profession become more sophisticated, but so has its patients, and now a simple, "Take two of these," no longer suffices.

Today's patient wants to know more. What happened? What's the cure? Why me? As patients become more informed about their bodies, their medications, and the methods used to treat them when they're ill, physicians are learning that they must become as adept with a phrase as they are with a stethoscope.

This issue of the *Journal* has been designed to look at those physicians who are involved in the area of patient education on a rather grand scale — although it can be just as applicable to the physician in his or her own private practice.

We take a look at those physicians who have taken the time to listen to their patients' complaints and praises, and who then acted on what was thought and said.

We take a look at physician image. Now that physicians are stepping more and more into the public limelight, we step back to see the kind of reflection that's being projected onto the public eye.

And finally we take a look at some physician-to-physician communication — at the problems and concerns physicians have voiced to each other during focus group interviews, and at communications programs which they've helped to generate through the scope of the Ohio State Medical Association's Communications Committee.

Communications is no longer a "wave of the future." It's already the name of the game, and ready or not, physicians have become key players. We hope this issue of the *Journal* provides the perspective that physicians need to understand the game — and how to play it well.

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And Now . . . A Word From Your Doctor

By Karen S. Edwards

Over the years, television has inundated us with more make-believe physicians than Mattel and its toy doctor kits. We've had emergency physicians, friendly general practitioners and even a county coroner come on the air and try to show the American viewing public what "life in the trenches" is really like. But fortunately, here in Ohio we've almost always had the "real thing" to compare them with.

While the networks were giving us "Ben Casey" and "Dr. Kildare" in the early '60s, for example, WCPO-TV in Cincinnati was taking revolutionary steps in the area of public service (and, as it turns out, in the arena of TV medical shows) by giving us Al Thielen, M.D., and a program entitled "Call the Doctor." Dr. Thielen was the first real-life physician to ever debut on TV with his own show, and for the sole purpose of **educating** the public rather than entertaining them. It was a risky step to take. After all, how could a show that dealt with real illnesses (and no guaranteed happy endings) ever hope to compete with the imaginations of Hollywood's finest writers and its most dashing leading men? The answer is that it did compete, and compete successfully. After 20 years and 1,000 telecasts, "Call the Doctor" is still going strong in the Cincinnati area — and so is Dr. Thielen. And where are Ben Casey and Dr. Kildare?

Well, they've simply dissolved into prototypes of the next popular TV doc — the one that hit the screen in the mid-'70s — Marcus Welby. Of course, "Marcus Welby" had a healthy TV life — relatively speaking. But shortly after the kindly Dr. Welby began making house calls on national TV, WEWS-TV in Cleveland began another medical revolution. It introduced Ted Castele, M.D. — another real-life physician — onto its news team. Dr. Castele or "Dr. Ted," as he's more popularly known, is still preparing brief one- and two-minute reports for WEWS-TV news (and the occasional 30-minute program). And Dr. Welby? He's now pitching decaffeinated coffee. . . .

"Local TV stations across the state have recognized the value of a 'real physician' and have put the 'real thing' on the air."

Even today, we still have a selection of ersatz physicians roaming the tube. There's "Trapper John" on one station, and the actor who used to play "Trapper John" joking it up in a doctor's coat on another. Except, of course, in Toledo. In what is certainly the most unprecedented move yet in the saga of "The real versus the fictional physician," Toledo's WTOL-TV has put its locally produced real-life doctor show on prime-time TV. Right there between "M.A.S.H." (another medical cut-up show) and "Lou Grant" (well, not everyone's a doctor) — ironically preempting a little comedy called "House Calls." Toledo viewers are fortunate, indeed.

But that statement stands for all Ohioans. Fortunately, local television stations across the state have recognized the value of a "real physician" and have acted accordingly, putting the "real thing" on the air while other states sat back, content with their Kildares and Welbys.

And Ohio viewers are certainly fortunate to have not just a handful, but a positive host of physicians who are willing to give of their time and knowledge to help these viewers learn something new — about themselves and their health.

The physicians and programs profiled here are no longer unique. In fact, there are now so many physicians who could be included in a story of "Ohio's TV docs," that their stories alone could fill an issue. So we've selected just a few — the "firsts" or those who represent a specific area. By no means do we ignore the rest. Instead, we salute you — all of you — who have given Ohio television viewers a choice. . .and a little education for a change.

Ted Castele, M.D.
Cleveland

Making Headlines

"Are they crazy?"

The question had already been lobbed around two local television stations, and had now been volleyed to a third.

"What do you mean they want to do the *news?*" exploded one studio executive when he heard the idea.

But the Cleveland Academy of Medicine's Public Relations committee persisted. All they really wanted to do, they explained patiently, was pass on some health tips to the people of Greater Cleveland — courtesy of the Academy — and what better vehicle than a local news program?

"Actually, I think it's got potential."

Heads turned. The speaker was WEWS-TV's program director Bill Baker — a man who was in the position to give it a go.

"Let's try it," he suggested.

But probably even he held his breath. It was only 1975. Nothing like this had ever been done before, and America's love affair with health wasn't due to kick off for several more years yet. Then, of course, when all was said and done, Ted Castele, M.D., the physician chosen to be television's first news physician, was really only an amateur.

"I frowned and blinked too much during my audition," Dr. Castele admits.

But apparently, the public wasn't noticing. They were too busy listening. Within a short length of time, Dr. Castele's one- and two-minute health reports, which aired several times a week, were among the station's most popular features. Never mind the Marcus Welbys and the call-the-doctor shows. TV had just given birth to a brand new physician — the news physician — and the concept boomed.

"The idea spread like wildfire," Castele reminisces.

Soon, TV stations all over the country were hiring their own TV news physicians — including the two Cleveland stations that had originally questioned the sanity of such a project.

And WEWS-TV's "rank amateur" turned out to be its ace-in-the-hole. Dr. Castele was a natural.

"I became interested in the project from the beginning," Dr. Castele admits.

"A few colleagues at the Cleveland Academy of Medicine mentioned the possibility of having an Academy member appear on TV, offering health tips to the public." And, because he



Dr. Castele (left) interviews Sandusky ophthalmologist S. Baird Pfahl, M.D., in the controlled but comfortable surroundings of his own office.

was then President of the Academy, he was chosen to try out for the job.

The rest is history — a six-year history, in which Dr. Castele says he's learned a lot.

"When it comes to the show's content," he says in example, "people are interested in the practical, everyday kind of information they can use at home." But that lesson wasn't immediately obvious at the beginning.

"At first, I tended to overlook the simpler areas of health," he admits. Because of the nature of his work in radiology, he tended to focus on subjects that turned out to be too complex or sophisticated for his viewers.

"I learned that the general public isn't really concerned with the treatment of aneurysms and other complicated medical matters. They're willing to leave that up to the physician or the hospital."

So, Dr. Castele looks for those health items which are both reassuring and helpful to his viewers. Disease and disease processes — when they are covered — are explained in a positive light.

Of course, one of the positive factors of Dr. Castele's 80-hour work week ("which includes practice, plus medical society involvement, plus TV activity") is that subject matter for his TV reports is almost always at hand.

For example, at this year's Annual Meeting in Cleveland, Dr. Castele was able to assimilate two reports.

One report featured Sandusky ophthalmologist S. Baird Pfahl, M.D., past president of the Ohio Ophthalmological Association. Dr. Pfahl happened to be attending the meeting, and Dr. Castele was able to persuade him to go before the cameras and explain how certain illnesses (such as hypertension) can be detected during an eye examination.

Another report featured OSMA President, Stewart Dunsker.

"The camera crew came out to the Frederick C. Crawford Auto-Aviation Museum where the OSMA and the Auxiliary were holding their Social Function," he said. "There we were, surrounded by all these great old cars, and what do you think we did our report on?"

"You have to be more than just knowledgeable on a subject you're presenting, you must also be able to explain it in simple terms."

Seat belt safety, of course.

Other times, the reports come to him.

"Being a TV regular means a physician is always on call," Dr. Castele was quoted as saying in a past issue of *Medical Economics*. He recalled an incident where he was summoned to the studio from a wedding reception to comment on a stroke suffered by Mrs. Richard Nixon.

No matter what the subject is, however, there is another lesson which Dr. Castele always tries to keep in mind.

"You have to be more than just knowledgeable on a subject you're presenting," he says. "You must also be able to explain it in simple terms. You can't go over the head of your audience."

But instead, his messages seem to go straight to their hearts.

During a lag in Cleveland's polio immunization campaign, for example, a few well-chosen words from Dr. Castele sent most parents packing their children off to their family pediatrician. Within days, the immunization rate was boosted more than 90%.

But his messages aren't the only thing the viewers have taken to their hearts. They've taken Dr. Castele as well.

These days, he's more than just a "familiar face" around Cleveland. He's "Dr. Ted" — and fortunately WEWS-TV recognizes what a valuable asset he has become. (After all, in three short years of competition, Dr. Castele has captured not just one, but four awards — two gold, one silver and one bronze — in the AMA's National Awards for Medical Speakers.) Last year — as much in appreciation as in practicality — WEWS designed, furnished and paid for Dr. Castele's new office in the Lutheran Medical Center — a room they then completely equipped with all the bright lights necessary for quick, impromptu filming sessions.

It's certainly an indication that TV has come a long way from its initial reluctance to put a physician on the news . . . and for medicine in general, and physicians in particular. That's good news, indeed!

Al Thielen, M.D.
Cincinnati

Batting 1000

Once TV's "French Chef," Julia Child was explaining to her viewers where different parts of meat come from. She finally resorted to using herself as the model, using her back, front and sides to show the source of brisket and T-bones and prime rib roasts. It may have been a little bizarre, but it got the message across — and if you don't believe it, jusk ask Al Thielen, M.D., a Cincinnati general practitioner who is not above using such visuals himself. Recently, he stood before WCPO's television cameras and used a similar technique to show viewers of his "Call the Doctor" program how to do a breast self-examination.

"I was demonstrating the method on myself," Dr. Thielen recalls, and it was only a short time after that incident that he was shown what an impact such impromptu visuals can make.

"I was visiting a patient of mine when a woman in the next bed said, 'Dr. Thielen, you don't know me, but you saved my life.'"

Apparently, she had watched that particular program, and had done the examination right along with Dr. Thielen. She detected a small lump in one of her breasts and had gone in to her doctor the next day. Because of Dr. Thielen and his own unabashed, innovative "self-examination," her cancer had been checked in time.

That story is but one from a storehouse of memories that span some 22 years. Al Thielen, M.D., is something of an original, a "Real McCoy" in a world that produces thousands of imitators. His program "Call the Doctor" was the first "real-life" medical television series to air in the United States (the show has since been copied by many stations across the country), and this past August Dr. Thielen completed his 1,000th broadcast of the show. And he's **still** going strong.

"I never get tired of doing the show — it's fun," he says. Even as he talks, his enthusiasm is obvious, but it had never been his original intent to stand before the cameras.



Top: Robert Howard, M.D., (left) and then station head, Mort Waters, present a plaque to Dr. Thielen upon completion of his 100th broadcast.
Bottom: Donald Radin, M.D., (right) President of the Cincinnati Academy presents an outstanding service plaque to Rick Reeves of WCPO, in honor of Dr. Thielen's 1,000th telecast of "Call the Doctor."

Al Thielen, M.D., is something of an original, a "Real McCoy" in a world that produces thousands of imitators."

"Mort Waters, who was the station head of WCPO at the time, was a friend of mine and he used to talk to me about putting some kind of medical show on the air," Dr. Thielen says. "I was the Chairman of the Public Relations Committee for the Cincinnati Academy of Medicine then, and of course in that capacity, the idea appealed to me. We then learned of a one-time show that had been done in Philadelphia called, 'What Price Health?'. We obtained a kinescope of it — they didn't have tape in those days," he says, speaking like a seasoned TV veteran, "and we loosely built our format around the one they had used. Originally, I had intended to serve behind the scenes as a coordinator for the show, bringing the physicians they needed onto the program. But George Winters, who was producing the show (and still does), wanted a physician as moderator."

Dr. Thielen got the job. As Public Relations Chairman, he had already chalked up some television experience by doing public service announcements for WCET-TV, and he had helped moderate a brief series of discussions on medically related topics on WLW-TV. But one look around his office shows that his modicum of TV experience wasn't all that recommended him.

On almost every wall of his office hangs a chart or graph which serves to educate his patients. There are charts which show "The right way to exercise," "Proper food to eat," and a complete muscular-skeletal chart which can be used to visually show the patient where his or her problem lies. The Ohio State Medical

Association's "Lifestyles" posters are prominently displayed along one wall, and copies of OSMA's patient education newsletter, "Synergy," are kept current in the waiting room. Dr. Thielen is not just an advocate of "patient education" — he's a living example of it and patient education is what "Call the Doctor" is all about.

"People want to live longer and be happy — and that means they have to stay healthy," Dr. Thielen says. "They want to know how to do that, and we have to show them." He leans back in his chair. "I like to think that we're doctors first, and teachers second."

Another look around his office shows that his lessons are never hard to swallow. Beneath the glass top of his desk are a score of cartoons which lighten the subject of reducing, remembering medications, and growing old. Obviously, Dr. Thielen's lessons are dispersed with a generous sense of humor.

"It's the same way with the show," Dr. Thielen will tell you. "We do the show in a relaxed, informal atmosphere. We use humor — we'll use biblical quotations if it will help get the message across," he says.

By "we," Dr. Thielen introduces the program's "service team" approach which he modestly claims is responsible for the show's success.

"Ten people are used on each show," he explains.

There are the panelists, usually four, who bring someone with them to answer the phones. That's eight. There is a coordinator, usually a physician, who will sift through the call-in questions for those which can be conceivably answered — that's nine. And, of course, Dr. Thielen, to moderate — ten.

"And don't forget our signer. She interprets the program for our viewers with hearing impairments. She stands there in her bare feet for an hour each week." Dr. Thielen is almost as proud of her as he is of the program.

"Everybody does their part," he adds.

He's delighted when he's recognized . . . "I'm a PR man for medicine," he rationalizes

But he is proud of the way the show is handled (with good reason) and of his part in it. He's delighted when he's recognized — and after 22 years of TV exposure, he is recognized — often.

"I'm a PR man for medicine," Dr. Thielen rationalizes.

He's also pleased that the program has become so widely accepted by members of his own profession.

"It's been called 'the medical school of the air,'" he says. "A lot of general practitioners like me watch the show so we can learn a bit more about those specialty areas. It's become something of a physician's educational tool."

But it wasn't always that way.

"Twenty-five years ago, this whole concept was considered highly unethical by the profession. It was considered a form of advertising," Dr. Thielen sits upright in his chair as if he were preparing to defend himself all over again. "I don't mind telling you I received letters from some colleagues when I first started doing this show." He shakes his head, then he relaxes a bit. "But I'm a general practitioner. I'm not looking for referrals," he laughs. "I'm still convinced we're doing the right thing."

So apparently are the majority of Cincinnatians. Recent studio statistics show that 1000 "Call the Doctor" programs are reaching 96 million homes. And the program, though live on Sunday, is rebroadcast on Saturday to meet the demands of thousands of churchgoers who can't be there to see the show firsthand.

Despite all the plaques, certificates and awards which hang in Dr. Thielen's office, recognizing both he and the part he has played in pioneering the area of televised patient education, those statistics are probably the thing of which Dr. Thielen is most proud. After all, when you're a teacher it's nice to know that your students are listening.

Victor VerMeulen, M.D.
Columbus

Surviving the Changes

The building next to Columbus' Grant Hospital has turned silent and dark. The white-coated technicians, nurses and office staff who work inside have long since disappeared and have no doubt settled down before hot dinners.

But inside the building, dinner is still a long way away for Victor VerMeulen, M.D., the otolaryngologist who, each week, moderates WCMH-TV's "Doctors on Call."

"Doctors on Call," the public service program which airs in Columbus each Sunday, has been through more changes in its ten-year history than a cowardly chameleon. The concept for the show (a throwback to the "Call the Doctor" show which Al Thielen, M.D., had begun in Cincinnati. . .see "Batting 1000") was hatched in 1972 between WCMH-TV and William Rigsby, M.D., who was then Chairman of the Columbus Academy of Medicine's Public Relations Committee. The show began with a nonphysician moderator and went through two of those before James Barnes, M.D., took over the moderating duties in 1973.

At that time, the show was still live and used a call-in format where viewers were able to phone in questions that occurred to them as they watched the show. But in 1976, WCMH decided to tape the show on Wednesday nights, making the call-in format no longer possible. The moderator had to begin anticipating those questions which the viewer might ask, and ask them himself of the panel. It was shortly after this change that the week-in, week-out moderating duties began to take its toll on Dr. Barnes' already hectic schedule. Gene Vassy, M.D., was called in to help with the moderating chores, and he later became a comoderator, filling in when Dr. Barnes' schedule wouldn't permit him to be there. But WCMH preferred a one-moderator show.

In 1979, Dr. VerMeulen, who had been a frequent panelist on the show, was asked if he would assume the duties of full-time moderator — on a six-month trial basis. He consented to do so, and he's been with the show ever since.

"I try to involve the people who are watching the show by involving myself. I show them physicians are human, too."

So it is that tonight, as on all Tuesday nights (the nights before taping), Dr. VerMeulen is still in his office — putting his own hot dinner on hold for awhile.

He loosens his tie and picks up a printed letter from the station which lists the next show's subject and panelists.

"Dr. Barnes had to do a large part of the planning of the show himself. He'd have to find his own panelists each week," Dr. VerMeulen says. "When I accepted the moderating duties, I did so under the condition that the station would take care of all that for me. Though I will make suggestions as to who to have on the show, it's up to the station to get in touch with them."



Dr. VerMeulen calls each panelist before taping the show.

So each week he receives the printed letter with all the preliminary footwork already done. Then it's his turn.

He reaches for the phone. Before he leaves tonight, he will have called all of the panelists listed in the letter and reviewed with them possible questions he may ask during the taping. He will determine their areas of interest in the subject, and their areas of expertise. When he arrives for the taping tomorrow night, he will be ready. And so will his guests.

"Sure the job takes time," Dr. VerMeulen says, "but it gets easier the longer I do it. I'm getting used to it, I guess."

He's learned that there are four or five basic questions that everyone wants to know about an illness, and it is around these questions that he builds each show's format.

"We define the illness; give its cause; tell them how we diagnose it; what the symptoms are; and how to treat it."

But Dr. VerMeulen believes in taking the show one step further. "I try to involve the people who are watching the show by involving myself. I show them that physicians are human too, with health problems just like them."

On a recent program on asthma, for example, he talks about his own experience with the problem, and he is never above resorting to levity when the occasion demands it. When he turned up in an identical jacket to one of his panelists on another show, for example, he interjected during the taping, "You realize that if you had been wearing the same color tie as me, I would have had you remove it all. . ."

"I ask stupid questions," he says almost enthusiastically, then on second thought he rephrases it. "Well, ordinary questions. That's one area where Jim Barnes and I disagreed. He'd ask these brilliant questions. But I don't know whether the audience cared as much as another physician did about having those kinds of questions answered."

The show is designed to educate the public, and Dr. VerMeulen feels that it's his responsibility to have it do just that. "The show not only teaches them about a specific illness, but exposes them to different specialists so that they know, when they have the illness, what type of doctors they will be referred to or asked to consult with."

And of course the show presents a positive image of the physicians, Dr. VerMeulen says, though he appears to

be a little less comfortable with his own image.

"I don't watch myself. Maybe I should. I might learn how I could improve the way I do the show. But nobody I know watches me either."

When he is recognized, he admits his discomfort increases.

"I don't like the idea of being a celebrity. I don't enjoy the notoriety, the recognition that goes with the show."

And there are a few things about the show itself he'd like to change. Because of a smattering of background in TV production ("when I was teaching at Ohio State, I took some courses in the area") he recognizes that TV usually involves more action than the show's present format entails.

"I'd incorporate more visual aids, more movies if I could. For awhile, I used OSU's audio-visual library, and brought movies with me. But that became too time-consuming."

All in all, he's happy with the show and the satisfaction he gets from doing it well.

"When the panelists have responded well, when there's been good interaction, and everything's gone smoothly, that's when I've been most satisfied with my role as a 'TV doc.'"

At least it seems to get him through all those late suppers. . .

Academy of Medicine of Toledo and Lucas County

Combining Efforts

"Sure we have television doctors," Lee Wealton, the Executive Director of Toledo's Academy of Medicine seems almost affronted. "In fact, our communications program is pretty active."

Indeed it is. Although there is no **one** specific physician who serves as the Academy's "familiar face" (as is the case in Cleveland, Cincinnati and Columbus), Kathy Lewton, Public Relations consultant to the Academy, feels that's all for the best.

"Our approach — that is, using many physicians rather than just one — is designed to let the public know that doctors as a group," she stops to place emphasis on that last, "are concerned. I think having as many doctors as feasible involved with these shows is good for the image of physicians."

There are currently three major communications programs, sponsored by the Academy, with which member physicians can become involved.

One of these programs involves the use of a consulting "physician-of-the-month."

"We focus on a general health topic each month — sleep, stress, diet and nutrition, inoculation, exercise, whatever. We send out newspaper columns on the subject to the weekly papers, and public service announcements (brief recorded messages) to radio and television stations. Our physician-of-the-month helps to edit the copy for medical accuracy and then makes himself or herself available during the month for interviews."

Phone interviews with radio stations are the kind most frequently sought, Lewton says, but usually the physician is also asked to appear on a local TV station's "Community Showcase" program which airs on Sunday morning.

However, if the member-physician is reluctant to devote an entire month to public relations activities, but still does not mind lending his or her skills as a consultant, then they can opt for one of the "physician expert" slots on "AM Magazine."

"AM Magazine" is an hour-long, locally produced show, which uses the magazine format approach currently so popular. Until recently, the physician would go down to the station and appear in a live interview with the show's host, Paul Smith.

"But we are now in the process of switching to a new format," Lewton says. The new format involves pretaped, straight-to-the-camera messages from the physicians who will, in essence, be giving brief mini-reports on a specific topic rather than answering questions.

"Right now we have nine physicians working on this program, and it's been very well received," Lewton says. She also points out the advantage of

"Our approach — that is, using many physicians rather than just one — is designed to let the public know that doctors, as a group, are concerned."



WTOL Moderator, Paul Smith, discusses the effects of alcohol with Academy member, Deirdre O'Connor, M.D.

delivering these messages to a morning audience.

"Our subject matter on this show is generally heavy on children's and women's health, but we think that mothers can really influence their family's lifestyles," Lewton says. She feels that the morning format is perfect for this approach.

But the Academy hardly neglects the evening viewer. In fact, in what can generally be considered as something of a coup in the world of television production, the Academy of Medicine of Toledo and Lucas County has managed to place quarterly television specials in what may be the most prime time on the air today.

"We're very lucky that WTOL is dedicated enough to our show to give us the Monday, 9:30 p.m. time slot. It's one of the best in prime time," she says, and few would disagree. After all, with the perennially popular "M.A.S.H." as a lead-in, and the award-winning "Lou Grant" to follow, you can bet your Nielson ratings that the Academy's show gets its share of viewers.

The programs which run under the title "In Good Health" are sponsored by Blue Cross ("illustrating the cooperation between physicians and insurers," Lewton says). Representing the Academy, Lewton helps the WTOL staff to select topics, do research, arrange interviews, and find the physicians they need to do a show.

"We usually have at least two or three physicians on each program, but each show is handled differently, depending on the topic."

The program on heart disease, for example, featured an introductory report on the subject, using Thomas Abowd, M.D., a Toledo cardiologist, as the source of information. Then the viewers watched a patient go through a cardiac work-up.

"Dr. Abowd, Dr. Franz Berlacher, and Dr. Lyle Holland then participated in a question-and-answer session, which was recorded exactly as it happened," Lewton says.

Another show on alcoholism, however, used not only a report from physicians Deirdre O'Connor, John Newton, and L.E. Whitmire, but also interviews with a recovering alcoholic and his family, a teen-aged alcoholic, and an alcoholism counselor. The audience was quizzed on its knowledge of alcoholism, and while another question-and-answer session was held, this one was taped and later edited.

"In what can be considered something of a coup, the Academy has managed to place quarterly specials on prime time TV."

"We're in production now on a show on inoculations for children," Lewton says. "Drs. William Buganski and George Nankervis will be our experts, and this time the question-answer session will be held live — our first time for that. Viewers will be able to call in their questions."

A program on lung disease will follow this winter.

"Fortunately, we have a lot of talent to draw from, Lewton says in summing up the Academy's responsiveness to such an active communications program. "And by dividing up the appearances, we don't tie up one or two doctors for a lot of time, or really impose on their busy schedules. They can participate on a periodic basis without feeling burdened."

Combining efforts is just one approach to the communications game, but it's an idea which, thanks to Toledo's initial effort in this area, is bound to catch on.

Don't go away, there's more

We wish this issue had more room. If it did, we'd be sure to include stories on these other Ohio physicians who also appear on camera:

John Vester, M.D., Cincinnati

It's hard to tell whether Dr. Vester's talents shine brighter when he is on camera or behind it. As one of the "experts" on WKRC-TV's "Eyewitness News" there's no doubt that his one- and two-minute reports bear the marks of a professional — or at least a paraprofessional — of the business, even though his real specialty is internal medicine.

Actually, Dr. Vester's on-camera experience goes back to the late '50s when, as a faculty member of the University of Pittsburgh's College of Medicine, he was frequently "on-call" as a spokesman to the local television stations.

But he has also chalked up plenty of behind-the-scenes experience as well. He's produced, directed and written educational films, TV documentaries and, most recently, a story line for the television series "M.A.S.H." Remember the episode entitled "Mr. and Mrs. Who?" If you do, then you may also have a hard time deciding just where Dr. Vester's talents shine best . . .

Christopher Kircher, M.D., Cincinnati

In this issue of "Ohio's TV docs," Dr. Kircher is the newest entry. This fall, he will begin his second season as "staff physician" on the WCPO-TV news team, where he regularly presents a feature "To Your Health" during the Seven O'Clock Report. As with Dr. Vester, his work also extends beyond the camera. Each week, he selects a topic, drafts the script and acts as both host and producer for his segment. Dr. Kircher is also "on call" for comments when a report on a timely medical development surfaces in the news.

A practicing neurologist, Dr. Kircher also manages to find time to serve as chairman of the Cincinnati Academy's Public Relations Committee, and to occasionally fill in for Dr. Thielen on "Call the Doctor" when the latter can't be there.

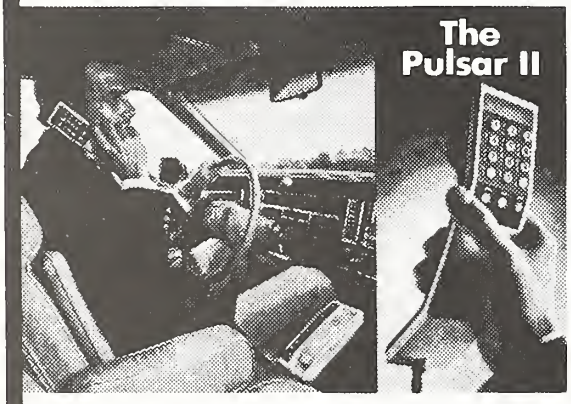
In fact, Dr. Thielen recently paid Dr. Kircher one of the highest compliments a "TV doc" can receive.

"We use Chris," Dr. Thielen said, "because he seems to relate well to the public — and they like him."

Fred Suppes, M.D., Cleveland

Television shows which follow a magazine format are popular all over the country, but perhaps especially so in Cleveland, where family practitioner Dr. Fred Suppes appears weekly on locally produced segments of "PM Magazine." Dr. Suppes' candid presentation of current health topics has done much not only for the show and its station, but for the role of patient education in general.

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Medical Forums:

A view from the public arena

By James Curry, M.D.

In recent years, the presentation of medical forums cooperatively produced by a medical group (such as the medical staff of a county medical society), in conjunction with a representative of the media, have been used to great advantage. The tremendous gains in public relations are noteworthy as well as the public service accomplished by presenting up-to-date and interesting medical facts.

In our local situation, as with most similar efforts, the advertising and financial responsibility usually rests with the media representative. The development of the medical programs, of course, is the responsibility of the medical representative.

Early last spring, the *Mansfield News Journal*, working with the Richland County Medical Society, presented a series of three medical forums, each lasting an hour and a half, and separated by two-week intervals. A fair amount of background preparation was necessary for the successful presentation of these forums. First, the PR representative of the county society formed a small committee totaling four individuals who met with a representative of the newspaper to discuss the general format. Since the newspaper editor had previous experience, his input was most helpful. With his direction, the above-mentioned format was approved. It was then the responsibility of the medical group to decide upon topics of interest, find speakers, and carefully explain to them the means of presentation.

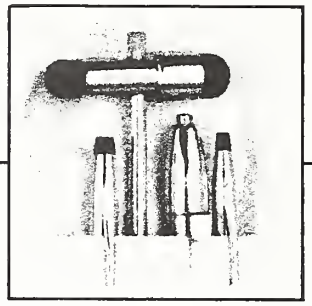
We established three general topics which were as follows: "Cancer, New Prospectives"; "Your Health and Your Money"; and "Heart Disease." After all agreed that these would be of interest to the public, simple outlines of the individual topics were established and four speakers for each group were approached. The obtaining of speakers for the most part was a fairly easy thing. Those chosen were picked because of their communication ability and their ability to be clearly understood. One speaker (for the Economic Forum), was obtained through the help of the Ohio State Medical Association's office in Columbus. OSMA also was of great help in providing advice and serving as an excellent source of resource material.

"The obtaining of speakers, for the most part, was a fairly easy thing. Those chosen were picked because of their communication ability, and their ability to be clearly understood."

Initially, one informational meeting with the organizing committee, speakers and the newspaper representatives was held. Subsequently, meetings were held as necessary between the individual speakers in each group, so that they could organize their topics and interface their presentations effectively.

The format for each of the public presentations was relatively simple. In each presentation, a representative of the newspaper and the county society gave brief greetings and introductions. The media representative established the following format: Each of the four speakers was to talk formally about his area of interest for 12 minutes. The limitation of time was necessary for efficient presentation. After the four speeches, a question and answer period completed the forum. The newspaper in its advertisements had requested that the public submit questions relating to each topic which were accepted by the newspaper up to the weekend before the presentation. These questions were submitted to the medical panels in advance so that they were prepared to answer the questions presented in an organized way. Panelists also gave the newspaper representative three questions each for which they had done adequate research and about which they could respond when asked by the master of

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ceremonies. Although specific questions were directed to a specific panelist, the other panelists were encouraged to respond to these questions. In this manner, the entire hour and a half was fully utilized. No questions in any of the panels for any of the forums were entertained from the floor. The reasons for this are obvious. Since most people would be asking rather personal questions about their individual problems, poorly researched, incomplete and possibly embarrassing answers might result. The meetings were promptly ended by the M.C. after one and one half hours.

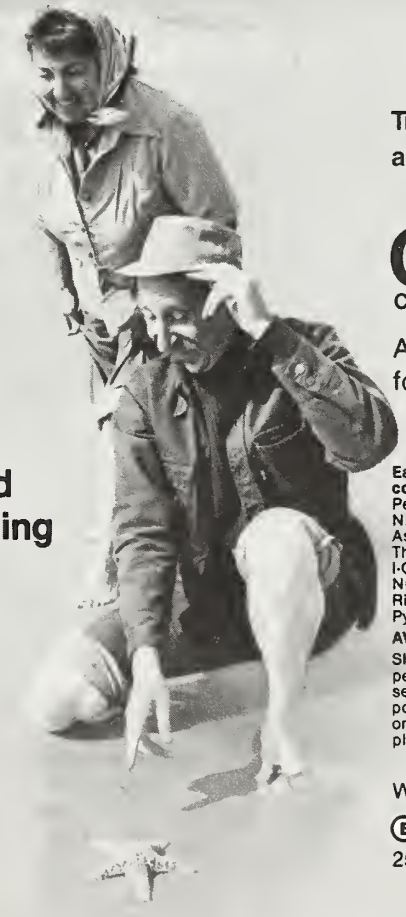
Admission to these forums was through tickets issued and controlled by the newspaper. Attendance was quite gratifying. The least popular was the discussion of socioeconomic problems. However, in spite of the slightly limited attendance at this meeting, the presentation of the problems facing individual physicians and hospitals involved in providing medical care was very worthwhile. The acceptance of these forums by the people attending was excellent; and following their presentations, the presenters were held for some time answering individual questions informally. It was difficult to measure completely the value of these forums. However, it was the impression by all those involved that the public relations value was very high. In a community where in the past physician-newspaper relationships have been at best marginal, the cooperative spirit between these two groups certainly was aided significantly by this effort.

A brief outline of the topics will be presented below:

1. "Cancer, New Prospectives"
   - A. Introduction, facts and figures
   - B. Treatment
     - (1) Surgery
     - (2) Radiation
     - (3) Chemoimmuno and combined therapy
2. "Your Health and Your Money"
   - A. Introduction (general facts and figures)
   - B. "Increasing Cost"
     - (1) From the hospital viewpoint
     - (2) From the physicians' viewpoint
       - a. Why?
       - b. What can we do? - Cost containment programs
     - (3) High cost of medical equipment
3. "Heart Disease" (with emphasis on ischemic heart disease)
   - A. Introduction with historical prospectives
   - B. Diagnostic procedures
   - C. Medical treatment
   - D. Surgical treatment with possibilities for the future

The success of this effort has been reinforced by the fact that plans are already being formulated to repeat the performance this year.

James Curry, M.D., is an OSMA member and is the Secretary-Treasurer for the Richland County Medical Society.



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Synergy

You and your doctor "working together" to keep you healthy.

By Carol Wright Mullinax

The dilemma facing physicians all over the country is how to keep the patients' ears once they leave the examining room.

The headlines grab them in grocery store lines: "New drug ends arthritis pain forever." "Amazing diet allows you to eat all you want and still lose." "Scientists discover the amazing sexual powers of celery." With rapt attention, they listen as talk show hosts tell them everything from how to cure acne to the need for zinc.

The public is hungry for health information; the media is determined to provide it. After all, public interest translates into advertising dollars. But in the mad scramble to provide the latest information, the medical data used is often incomplete, unproven and misconstrued. Almost every physician has witnessed firsthand patients who have been victims of this phenomenon. It isn't a new problem, people have passed treatments and cures over backyard fences for years, but in today's media-intensive society, the latest "cure" is only as far away as the nearest TV set or magazine rack.

The dilemma facing physicians all over the country is how to keep patients' ears once they leave the examining room. The Ohio State Medical Association's Public Relations Committee considered this problem a few years ago and decided that one way was to publish it's own health education newspaper.

Who, it felt, was in a better position to provide the public with reliable health information than an association with 16,000 physician members? And what better way to reach the public than through a publication placed in a physician's waiting room?

Out of that reasoning, Synergy evolved — a four-page monthly health education newspaper sent, as a benefit of membership, to all OSMA members. The decision to publish Synergy was a difficult one but it has paid off for the OSMA.

Since its inception, members have responded enthusiastically to the publication, viewing it as an important tool in their efforts to keep patients educated. One pleased member reports he left an anxious patient, whose father had recently suffered a heart attack, alone in an examining room with a copy of Synergy and returned to find him pouring over an article on heart disease. "This has answered all my questions," he said, "Can I take it home for the family to read?"

Responses like that one prompted the OSMA to offer Synergy to the public on a subscription basis. To publicize its availability, over 700 OSMA members place advertising placards with tear-off subscription forms in their waiting rooms. At $4.95 a year, it is a bargain that an increasing number of patients are taking advantage of.

To reach even more people, last year the OSMA contacted all Ohio high schools about using Synergy in the classroom. The response was excellent. In addition, the OSMA is talking with industries about providing Synergy subscriptions to employees as part of

continued on page 615

Is Anyone Out There Listening?

By Gina DiBlasio Cummins

How would YOUR patients rate you and your practice?

A) Outstanding — absolutely no need for improvement.

B) Quite satisfactory — maybe a change here and there.

C) Acceptable — but you're really not sure.

When two OSMA physicians asked themselves this question, they weren't about to settle for "C." They wanted to be sure. These enterprising doctors took matters into their own hands — and conducted a patient survey.

They each went about their separate ways devising and tailoring a survey to suit their specific needs. It didn't matter that one was from the big city of Cleveland and the other from the small community of Van Wert, their purpose was the same: to find out what their patients thought about them as well as certain aspects of their practices (and to let them blow off a little steam in the process.)

To their satisfaction, overall response was not only positive, but downright encouraging. And although they had always suspected that their patients were generally pleased, it was certainly nice to have it confirmed in writing!

Dr. Suppes feels that any way you look at it, his patient survey nine years ago, was, at the very least, "a little gutsy."

"When you think that you're doing okay, you're reluctant to experiment. But I was curious about what my patients thought, and that curiosity prompted me to go ahead with it."

The survey consisted of ten questions and was distributed to the first 500 patients who visited his office. Of the 500 surveys dispersed, 398 were completed and returned. He invited questions or comments at the bottom of the survey and allowed the respondents to remain anonymous.

"The nature of the survey reflected things that I particularly wanted to know, like, 'How they had been greeted by my staff,' and, 'Did they have a problem obtaining an appointment?' (361 said no.) I also asked questions which I thought they might want to comment on, such as 'Does the office appear to be clean and comfortable?' "

But after several of these less-important, preliminary questions, Dr. Suppes proceeded to the meat of his survey.

"One question I was afraid to ask was, 'Do you have enough time with me to have all of your questions answered and your problem evaluated?', "but I did," Dr. Suppes says, "and I was surprised to find out that 284 said yes, and 36 said no. It was a very pleasant response because that's the one thing that physicians really worry about — spending enough time with the patient. Some patients would just like to sit there for hours and ask questions."

Dr. Suppes broached another touchy topic; that of fees. Of the 398 responses, 32 felt that fees were too much, 331 felt that fees were satisfactory, and five patients felt that fees should have been higher.

The survey was also used as a means of educating his patients on the number of staff he employs. "So many times, patients only see the girl at the window and perhaps an assistant. They don't realize all the people who work behind the scenes combining their efforts to provide the patient with thorough medical care."

"Patients must have welcomed this opportunity to comment because the majority of them designated they would answer another survey in the future," says Dr. Suppes. "Some

"When you think that you're doing OK, you're reluctant to experiment. But I was curious about what my patients thought, and that curiosity prompted me to go ahead with a survey."

patients seemed to really enjoy answering the questions. They signed their names and even added some very nice comments like 'You've been my doctor for 100 years — I think you're just marvelous.' Only a couple of patients were miffed — they seemed to be the businessmen who wanted to get in and out."

Dr. Suppes feels that overall, response was very favorable. "Answers were pretty much as I expected but there were a few zingers where people took the opportunity to complain. One patient said 'No, he could not understand why he had to wait for his appointment because of an earlier emergency. When he made an appointment, he expected to be seen immediately.'

He believes that the most worthwhile result of the survey was to openly encourage and receive patient feedback. Learning that his patients were generally well satisfied was a bonus. "I may quickly add, however, that if a patient is dissatisfied with myself or my staff, they will go to another doctor."

Dr. Suppes feels that in our competitive society, a patient survey can play an important role. "It's a good opportunity for a doctor to conduct some public relations between he and his patients — to take the time to say things that he would like to say to the patient, but doesn't because he just doesn't have the time."

Although he does not have any immediate plans for a future survey, he is constantly conducting follow-up mini-surveys within his office to improve its efficiency and ultimate care for the patient.

Since Dr. Suppes believes that patient education must be a continuing process, he provides his patients with various pamphlets on diseases and has other booklets available in his office that patients can purchase. Whenever possible, he or one of his staff tries to answer patient questions over the telephone or during the examination.

"The important question to ask yourself is: Are my patients getting enough education while in the office or are they walking out not knowing what they're supposed to do? A patient survey may be one way to answer this question."

In 1979, Dr. Diller devised and distributed his first patient questionnaire.

It wasn't the first time he had considered his patients. A few years earlier, he had designed a patient information booklet for them which outlined his general office procedures. (In fact, the booklet turned out to be as popular with his peers as it was with his patients. Copies of it have

Breaking into print

In this competitive age, many businesses are becoming more customer-oriented. In order to communicate the services and advantages they offer, many are now offering some form of information booklet to the consumer.

Banks prepare pamphlets on the various checking and savings plans they offer, insurance companies list different policies and rates in booklet form, and restaurants are providing patrons with sample menus that include reservation information, house specialties and price ranges.

Why shouldn't physicians jump on the bandwagon and supply patients with information booklets as well?

Improved patient relations and something as simple but desirable as saving time, are just two benefits of such a service. A short and inexpensively reproduced booklet can maintain and improve your relationship with your patients and reduce the many hours of repetitive explanations your staff ordinarily handles.

The booklet should be kept as simple as possible and clearly state policy for staff and patients. Remember to include information that YOU would want to know if visiting a physician's office.

1. **Specialty and type of practice.** For example, inform your patients whether your practice is geared to pediatric patients 18 years and under, or surgical cases. If you are a member of a group or partnership, inform your patients how this advantage assures coverage in your absence.

2. **Appointments.** How far in advance should a patient call to make an appointment? A year in advance, six months ahead? What is your policy about squeeze-ins? This information will vary from specialist to specialist, so let your patient know what **your** policy is.

3. **Office hours.** List your office hours, the days the office is closed and indicate individual doctor's schedules if you're a member of a group practice. You can also discuss your policy about house calls, evening, weekend and holiday coverage.

4. **Telephone calls.** Inform the patients who to call in case of an emergency: your office, the hospital, or an ambulance service. You should also provide patients with a list of the hospitals where you have privileges. Do you charge for telephone conversations? Will your office notify patients of lab test results or should they call you? These questions can all be answered in the patient booklet.

5. **Your fees, billing and collection system.** Since fees are a delicate topic that many patients find difficult to discuss, initiate the subject in your booklet. Tell patients about your fees, indicating the variance for different procedures such as lab tests, etc. Do you prefer payments at the time of the visit or will you send a monthly statement? State your policy about overdue bills and the use of collection agencies.

Once you have the basic information you wish to relate to your patients, communicate it in a friendly and conversational tone. Explain your policies, when possible, in terms of the patient's self-interest.

Through good communications, you can develop a successful physician-patient relationship and enjoy the benefits — a courteous and happier staff that will reflect a smoother running practice. Patients will not only be satisfied with their medical care, but by your thoughtfulness as well.

Gina DiBlasio Cummins

since been sent to offices all over the United States, and as far away as several Caribbean islands.)

"I think that fast food slogan, 'We do it all for you' reflects the kind of feeling we try to convey to our patients," Dr. Diller says. "All of our efforts are directed at providing them with a concerned and caring environment. We want to do whatever possible to make the patient feel their well-being is our business."

So it was, that in 1979, Dr. Diller set out to learn what his patients thought about his practice.

"I felt that we needed a two-way communications system with the patient, something to supplement the booklet. A questionnaire was the logical answer."

Some might feel that Dr. Diller asks for trouble — with that little stack of cards in his waiting room — but what he's really striving for is feedback. As he puts it, he prefers stated complaints to stewed resentments.

"If you really desire a two-way communications system, you have to give patients an opportunity to render their opinion — favorably or otherwise," he says, adding that, "If you are a specialist and only see a patient once or twice, it doesn't matter. But when you have a semirural practice in a small town, and you take care of the same patients year after year, you must build a meaningful, personal and caring relationship."

Some might feel that Dr. Diller asks for trouble, but what he's really striving for is feedback. He prefers stated complaints to stewed resentments.

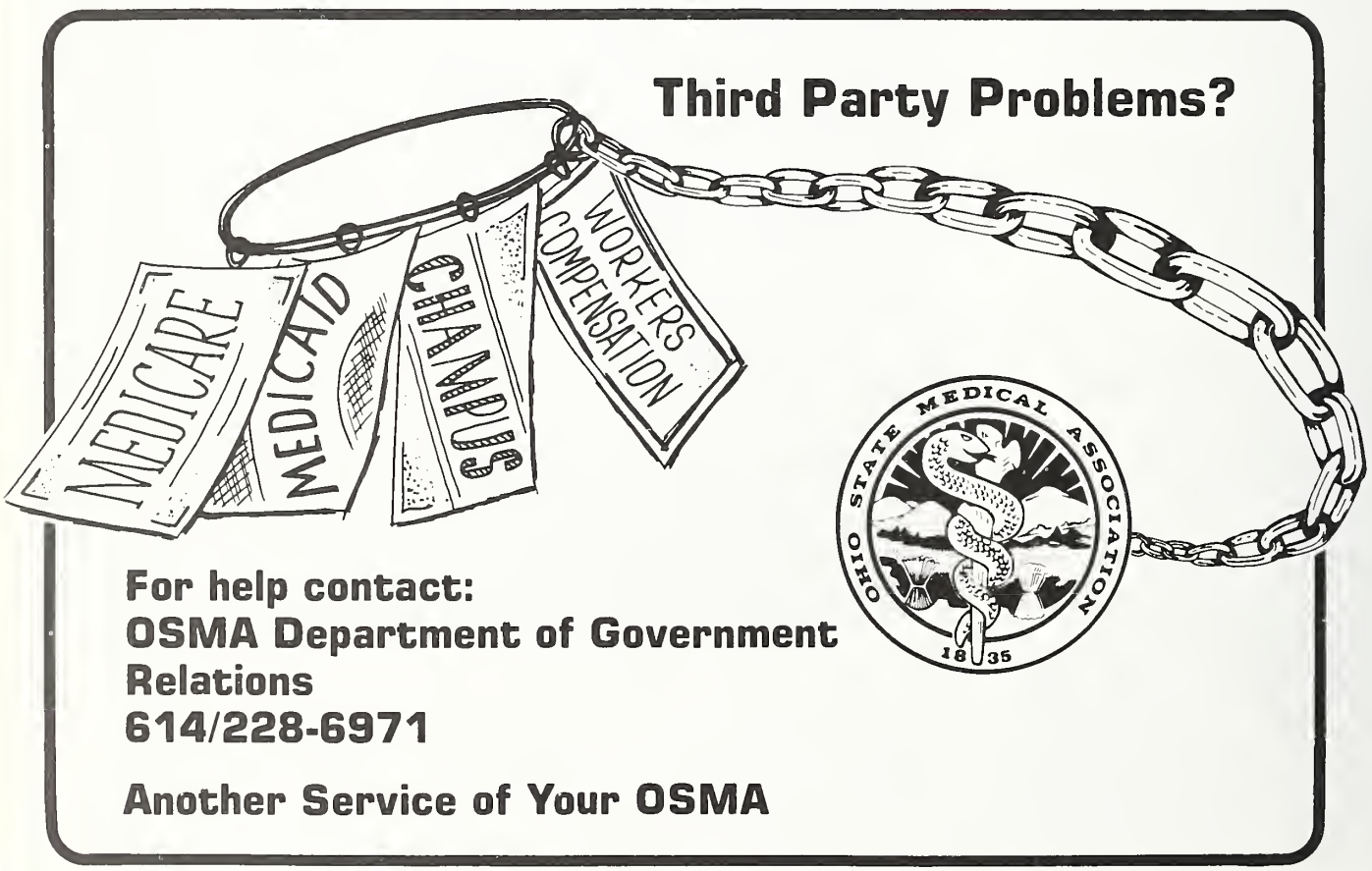
Dr. Diller feels that communicating this caring feeling to the patient is necessary to maintain a successful practice. "Many practices could become short of patients unless preparations to strengthen them begin now," says Dr. Diller, adding that, "Unless doctors learn how to become better marketers, many physicians will either have to relocate or have a difficult time securing income."

Dr. Diller agrees with Dr. Suppes that physicians are entering a competitive era and both feel that competition is going to be a major factor in the future of medicine.

The patient survey, as both these physicians have learned, is one valuable marketing tool that can effectively strengthen a practice. And both agree that a patient survey not only offers a two-way communications system with the patients, but gives the doctor a foundation on which to build a solid, lasting relationship.

In fact, the survey he created **could** be the longest-running one on record — it's **still** going on. A pile of surveys is always kept on the sign-in desk in the waiting room, ready to be completed, signed or unsigned — either by new patients or patients with something new to say.

"The questionnaire serves several



purposes," Dr. Diller explains. "First, it tells the patient that we care, and secondly, that we are interested in communicating. It also gives the patients a chance to vent their feelings if they dislike a minor or major deficiency in our system."

One possible deficiency that concerned him was the amount of time patients were being placed on hold when phoning in. One patient had his own creative solution to the problem, however, and wrote, "Sometimes it helps when I say I'm calling long-distance — even though I'm not."

The efficiency of his office staff is another of Dr. Diller's concerns. Most responses have been favorable, but one elderly patient pointed out that she resented a nurse who was young enough to be her granddaughter, calling her by her first name. Another patient commented that scheduling shorter waits for patients with small children would not only be more convenient for parents but less trying on others in the waiting room.

Dr. Diller admits, however, that many of the comments are constructive, and that for every ten favorable questionnaires, he receives one critical comment. "And that's usually on a day when the office is very hectic."

"The questionnaire serves several purposes. First, it tells the patient we care, and secondly, that we are interested in communicating."

On one particularly crowded day in the waiting room, for example, a patient candidly commented that while he was treated fine by the physician, he "couldn't help but feel like part of a herd of cattle passing through to be branded." The patient even signed his name.

Want to conduct your own patient survey?

If you would like to conduct your own patient survey but are unsure as to how to go about it, the Ohio State Medical Association's Department of Communications would be happy to help you out. A prototype survey will be sent to you upon request and any individual assistance you might need in preparing your survey can be provided by Communications staff members. Please call or write the Department of Communications, The Ohio State Medical Association, 600 S. High Street, Columbus, Ohio 43215, 614-228-6971.

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Hello, How's My Image?

By Richard A. Memo, M.D.

Editor's note: The following article has been reprinted, with permission, from the **Bulletin of the Mahoning County Medical Society.** *Although the editorial was written for Mahoning County members, we feel that its message has broad appeal, and is especially appropriate for this Communications issue.*

The other day I passed a physician in the hallway who once again walked past me and several other people without returning a hello. Since it is a daily occurrence with this person to ignore a hallway greeting, my first impression was that he projected a "bad image" as a physician. On careful thought, however, I questioned what the importance of such a projected image might be. Should he try to convey a smiling appearance and be pretentious, or should he portray his more natural aloof disposition which, our psychiatrist colleagues tell us, is healthier. Public presentation and fear of criticism have become progressively less important in the past twenty years. The individual has become desensitized to the need for an image.

On a group scale, a diminished view of physicians has also led to many concrete changes in the style of medicine. Second opinions, more patient information distribution, and calculated interactions between physician and patient have become part of daily practice. Whereas the traditional role of the physician projected him as knowing more than he probably did, the current estimation seems to undercut his knowledge. At a time when we are experiencing a medical knowledge explosion, the coordinator of that knowledge, the physician, is doubted more than he ever has been.

Now that government heat has been taken off the private practice of medicine with the new President's administration, there is time for the doctor's image to be cleaned up. Perhaps through well-directed efforts the esteem of private practice can be regained.

"Physicians are necessarily such a diverse group, that no campaign to convince people that they are a 'bunch of nice guys' . . . would ever, or should ever work."

For example, more intense examination of medical society's interaction with the nonmedical aspects of the community must be done. Perhaps active solicitation at speaking engagements, community medical projects, and more events with nonmedical professions, would be initial steps to better expose the medical skills and concerns that exist in the community. Further, the State specialty societies and national medical societies should attempt to publicize our positive attitudes. Medicine's association with the scientific method, intellectual honesty, rapid advancement of our technology, and concern for the public should be reemphasized via news media and transmitted communications. The attempts should not be to make medicine look like something it is not but rather to update the public on the services that can be provided on a community level. Physicians are necessarily such a diverse group that no campaign to convince people that they are a bunch of nice guys applied to medicine would ever or should ever work. Positive action at the society level is necessary to update the public's knowledge of us so they can make sounder judgment.

As the society attempts to address the problem, the individual should also try to bolster his esteem with the public. Little gestures may be cumulative. For example, a polite "hello" to a passerby in the hallway might be a way to convey a friendly physician image. On one hand it might be argued, how could this help the individual and all of medicine? On the other hand — it could be challenged — would it hurt.

Richard A. Memo, M.D., is a member of the OSMA, editor of the **Mahoning County Bulletin,** *and practices urology in Youngstown, Ohio.*



Tap Dancing in a Minefield

By Karen S. Edwards

Suddenly, in front of *you* are the camera, the lights, the reporter with poised pen, ready to jot down your every syllable . . . Then, what is it like?

Along about six o'clock every evening, Dan, John, Roger, Frank, et al, assemble behind their stage-prop desks and dispense the news before a battery of television cameras — unblinking and cool as cadavers. In fact, they are so nonplussed about the whole business that they could be sitting beside you in your living room, sharing with you their learned intimacies about Anwar Sadat and Ronald Reagan. The cameras, the lights are just part of their every-day razzle-dazzle world — and when you're as highly trained a professional as Dan and company, you simply learn to take all that fancy footwork in stride.

But what if you're John Q. Public, M.D., and you have a little practice in Smalltown, Ohio — and suddenly the local media taps you as the authoritative source for a story they're doing on the bubonic plague? Suddenly, in front of **you** are the camera, the lights, the reporter with poised pen, ready to jot down your every syllable (carefully couched in laymen's language, of course). Then what is it like?

"Well, it's a little like tap dancing in a minefield," says Roger Ailes — and he ought to know.

For at least some twenty-odd years, Ailes had made a profession out of easing prominent nonprofessionals into the fast-paced world of television.

Part of his experience comes from his days as executive producer of the syndicated "Mike Douglas Show," a popular talk show that began in Cleveland, Ohio and moved west as ratings increased.

Today, he produces "Tomorrow Coast-to-Coast," the remodeled NBC "Tomorrow" show which — thanks largely to Ailes' efforts — still stars the argumentative team of Tom Snyder and Rona Barrett.

Newspaper accounts totally credit Ailes, and his ability as a TV troubleshooter, for patching up the reported ego rift between Snyder and Barrett, and putting the show back on

its feet.

"Roger Ailes is the Red Adair of TV production," writes columnist Marvin K. Show in an issue of the *Long Island Newspaper*. "They call him in to put out the fires."

So Ailes knows all about tap dancing in minefields — and how to survive the explosions. It's information that comes in handy in his second occupation.

"He (Ailes) is one of those TV producers who doesn't have to work in TV," Show writes. "He is a successful political media consultant."

"The problem with doctors and communication is that doctors are not trained to communicate."



Roger Ailes . . . He knows all about tap dancing in minefields, and how to survive the explosions.

Successful enough to have put Richard Nixon in the White House (for better or worse), and Alfonso D'Amato into the U.S. Senate. In fact, it was Ailes' prowess at politics that brought him to the attention of the Ohio State Medical Association, and eventually to its Annual Meeting as speaker for the annual OMPAC Luncheon. Of course, his relationship with OSMA member, Robert Ailes, M.D., of Cleveland, didn't hurt. As Dr. Ailes puts it, "Roger's my baby brother."

But it certainly would be difficult to find anyone more qualified to speak on physician image — or to advise the physician recently recruited into show biz — than Roger Ailes. After all, he's the man who has been there — who has put others there — and who just so happens to have his own personal link to the medical community.

"The problem with doctors and communication," Ailes says in an overview of the situation, "is that doctors are not trained to communicate. Yet, every day, they are called upon to do just that — in a number of ways."

They communicate one-to-one with their patients; as expert witnesses in a courtroom situation; and as spokespeople for the local and even the national media. It's doubtful that Dr. Donald O'Leary's medical education ever included press conferences, and yet, when the attempt was made on President Reagan's life, somebody was needed to help answer the medical questions posed by a room full of reporters. All the press secretaries in the world — armed to the teeth with journalism degrees and years of public relations experience — just didn't have the credentials for the job. It took a doctor.

"Like it or not, the physician has to assume an active role as communicator," Ailes says.

"Part of the reason is that physicians maintain a sort of 'last deity' image in the community. They are often asked for their input — and the physician had better have something to say," Ailes warns, "or somebody else will speak for him."

Ailes is quick to point out that there are more and more people — besides MDs — who are doctoring today, and those people are more than willing to discuss medical issues.

"Doctors don't have a choice. They have to become comfortable with communications," he says.

But he recognizes that most are not.

"They haven't moved into the 20th century yet," Ailes laughs, then he ticks off on his fingers the three reasons most physicians give for not becoming actively involved with the media.

"Most physicians have a personal aversion to publicity. It's not considered ethical or dignified. Two, they're too busy — they have enough trouble just keeping up with their practices. And three," Ailes pauses, "they get caught in the trap of making absolute statements, when flexibility is what's needed."

"Appearing on television is frightening — especially since it has changed the way people expect others to act. They expect the person on camera to be cool and collected, to think fast on their feet and rattle off an answer to a question without thinking twice about it. And to be right."

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It's a rough place to start, Ailes admits, especially when oral communication is a skill that's largely neglected in the classroom.

"Small children are natural performers," says Ailes. "They haven't learned any inhibitions yet, so they just act naturally. In fact, the best communicators are those who have the ability to magnify their emotions," he says. "That's half the reason Reagan was so successful during his campaign for office. It's the best acting job he's ever done. But by the time most of us reach high school, oral skills are discouraged. If you sign up for a speech or drama class, you're labeled flamboyant. And physicians are even worse," he adds. "They're trained to be unemotional."

But, as he points out, avoiding the media isn't going to help brush up those skills — or solve the problem.

"All physicians should begin an intensive public relations program right in their own offices — with their own patients," Ailes suggests. "The biggest complaint we hear from patients is, 'My doctor won't talk to me.' But he should."

"As doctors, we're often considered to be family friends of our patients. They'll make an appointment with us, but sometimes all they really want to do is sit and talk," Roger's brother, Dr. Ailes, interjects. "It's sometimes frustrating, but we have to realize it's part of our job."

"Communication is actually a process of shared comprehension. But the responsibility rests on the physician to put that comprehension across."

But Ailes urges physicians to simplify when they do talk to a patient.

"The consumer movement has done much toward making your patient more aware. He or she is going to start asking more questions of you." But, he adds, you won't be communicating if all you're doing is confusing him or her.

"Communication is actually a process of shared comprehension. But the responsibility rests on the physician to put that comprehension



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across." Again, he turns to a political example.

"Reagan has a remarkable ability to simplify. He can hold up a dollar bill in front of the American public and say, 'Hey, look. This is only worth 36 cents.' He got his message across, and he got elected. Doctors are going to have to simplify in a similar manner for their patients."

But, according to Ailes, the one-to-one communication is really just the tip of the iceberg. When you scan the polls, he says, you'll find most people saying, "Gee, my doctor is great — but I wouldn't give you five cents for the rest of them."

"Malpractice suits, often publicized in the media, are in part responsible for this poor general image — and admittedly there are a number of reporters out there who have a Woodward-Bernstein complex. They don't like doctors and they're looking for the bad story."

"But the medical profession is not really a policed profession," he adds. "They're not tough enough on themselves. We've seen cover-ups in malpractice suits, and in cases of impaired professionals, where colleagues let things slide. That's the kind of thing that really hurts physician image," Ailes says.

"The American public is very forgiving — but they want to be told all of the facts."

He mentions the difference in the way Richard Nixon and tennis pro Billie Jean King handled their problems.

"Billie Jean King went straight to the media — and the American people — with the facts. Consequently, the American public will forgive her. But they're not likely to ever forgive or forget Watergate."

The physician is going to have to do the same thing if he wants his profession to survive — as it is — in the future, Ailes says.

"As experts, physicians don't want to take a stand, but they're going to have to. They should be ready to speak up and make a contribution to the image of their profession. Doctors could correct their own image if they want to. And let's face it — they had better want to. Because no one else is going to stand up and defend them."

"Doctors could correct their own image if they want to. And let's face it — they had better want to. Because no one else is going to stand up and defend them."

"And right now," Ailes warns, "is the very moment that physicians need to communicate the most."

Working with the media isn't always easy. It can be a frightening and frustrating experience — especially when the camera is on you, John Q. Public, M.D. But in this day and age, there's just no easy way to soft-shoe your way out of it. As Ailes suggests, the only thing you can do is to get out there in that minefield — and keep on tapping.

Karen S. Edwards is Executive Editor of the Ohio State Medical Journal.



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If you've just been recruited as "official spokesperson" by your local radio or television station — or even if you wish you had — you can find some small comfort in knowing it's not altogether a "sink or swim" situation.

For the second year, the AMA is offering its "Health Reporting/Radio-TV Conference," designed to teach the novice everything he or she needs to know about broadcast journalism, while providing the old hand with updated information and professional evaluation of his or her broadcast style.

As the AMA officials put it: "It's an excellent forum to meet other doctors, like yourself, who are on the air or who want to be."

The conference features workshops which help the doctor-reporter to explore his or her responsibilities; examine different health-reporting formats; and how to become involved with television's latest spin-off — cable TV. This year's speakers will include Art Ulene, M.D., the physician who gets NBC's "Today" program off on the right foot, and Dennis S. O'Leary, M.D., the physician who answered the media questions during the attempt on President Reagan's life.

If you have questions, or wish further information on these conferences, contact: The Office of Public Relations, AMA, 535 N. Dearborn St., Chicago, Illinois 60610.

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Synergy (continued)

their health benefits package and with other state medical societies about purchasing Synergy for their members. OSMA is the only state medical society to have a monthly health education newspaper.

Although pleased at the growing number of Synergy subscriptions, the OSMA keeps in mind that the original idea was to reach the public with reliable health information. To accomplish this, each month the Association sends four news releases based on Synergy articles to all newspapers, and radio and television stations in the state. They have proven to be very popular.

The need for a publication like Synergy increases as the public's interest in health care increases. Physicians who want to win the high pressure contest for the patient's attention can now spell relief, **S-Y-N-E-R-G-Y.**

Carol W. Mullinax is the Associate Director of the Department of Communications

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Focusing Concerns

By Carol Wright Mullinax

Caucuses — usually held in small, smoke-filled rooms used to be the exclusive domain of politicians. It was a pretext they could use to gather, away from the pressures of office, and discuss everything from the complexities of the new budget to the disgrace of ABSCAM.

But last year Ohio physicians took a lesson from the legislators and started meeting in their own version of the caucus.

These meetings, called Focus Group Interviews, were employed by the OSMA to help it become more familiar with the concerns and expectations of its members. Politicians get the ultimate feedback from their constituents — a yea or nay vote every few years. But for an association with 16,000 members, keeping its finger on the pulse of those it represents can be an overwhelming task. Yet it is crucial if the organization is to remain viable.

Starting in the summer of 1980 and continuing today, the OSMA Department of Communications, with the help of an outside consultant, is sponsoring a series of meetings around the state to talk with physicians about the future of medicine.

Four to ten physicians, (usually selected to represent all segments of OSMA membership by the District Councilor), are invited to attend an informal roundtable discussion which generally lasts two to three hours. Here, they are asked to talk about their concerns regarding the future directions of health care and to make suggestions as to what organized medicine can do to help alleviate those concerns.

Roger Blackwell, Ph.D., professor of consumer behavior at Ohio State University and long-time consultant to the OSMA, and his associate, Wesley Johnston, Ph.D., professor of marketing at OSU, serve as moderators during the interviews.

Focus Group Interviews are a relatively new research technique. While they are not helpful in supplying a quantitative measure of how widespread a view may be (this can be determined by membership surveys like the one the OSMA conducted two years ago), they are invaluable in providing an in-depth look at concerns, feelings and beliefs.

Thus far, what the OSMA has learned from these interviews has both reinforced some of its previously held ideas about issues facing medicine and introduced some new ones.

For example, the interviews revealed that government intrusion into the practice of medicine continues to be one of the major concerns of OSMA members. One interview participant described government intervention this way: "It makes me feel like the tentacles of the octopus are creeping down Main Street, into our building and saying, 'Boys, the show's over. This is how it's going to be.' This is what bothers me and my colleagues — this creeping insidious feeling of what is happening to the practice of medicine."

Many physicians agree that government intervention in the guise of red tape and endless forms, is building a wall between themselves and their patients. But other participants place at least part of the blame on physicians themselves: "The physician-patient relationship is increasingly under fire. Because medicine has become more sophisticated, we rely more — sometimes legitimately, sometimes as a crutch — on machines and diagnostic modalities we never had before. I think it depersonalizes the patient to some respect." But almost all of the physicians interviewed to date are pleased with the new wave of consumer interest in wellness and disease prevention.

One of the most controversial areas that has been raised during these interviews, however, is the impact of paraprofessionals on the future delivery of health care. There seems to be significant disagreement over the role these paraprofessionals should play. Some physicians believe that they are well-trained and invaluable in rural areas, while others have less confidence in the paraprofessional's ability and are worried that the quality of health care in those areas could deteriorate. However, many

(continued on page 619)

participants have felt that oversupply of physicians, predicted for the coming decade, will help to solve the problem of paraprofessionals — while creating whole new vistas of concerns. For example, the problem of competition.

Some physicians have already noticed signs of competition in their own communities. One participant said: "Our city has a lot of competition. A lot of general surgeons are out of work, and I think that is just the first specialty that we are seeing in trouble." As he points out, it is the specialty surgeons who are now getting work. There are ENT men doing head and neck; plastic surgeons are doing a lot of work, and proctologists are doing all the hemorrhoids. The only things the general surgeons are doing are gallbladders and hernias."

Some health care experts are predicting that if there is an oversupply, the resulting competition among physicians would lower the cost of medical care. Most physicians interviewed disagree with this opinion. Pointing to California, a state already experiencing an oversupply of physicians, one doctor said: "The guys out there may do half the procedures we do here, but they get paid more for them because there are so many of them and they have to make up the difference by charging more."

The depth of concern expressed by interview participants over competition in the field of health care prompted the Communications Committee of the OSMA to commission a study on competition. The purpose of the study, conducted by Drs. Blackwell and Johnston, is to assess the likelihood of competition in Ohio and to make recommendations on how the OSMA should respond.

All concerns voiced by participants, encompassing everything from third-party reimbursement to health education, are passed on to the appropriate department of the OSMA for consideration and possible action.

Although the physicians interviewed thus far have expressed generally the same concerns about the future of medicine, there has been no clear consensus on how organized medicine should respond to the problems.

One area of disagreement that sprung up, for example, was whether the OSMA should serve as a patient advocate or a physician advocate. Some physicians felt both the AMA and OSMA should act as a type of union for physicians to make certain their interests are protected in the future. Many other physicians were violently opposed to this concept, feeling that organized medicine's most important role is to protect the interests of the patient.

Out of the numerous opinions, beliefs, attitudes and concerns to come out of the Focus Group Interviews, one fact stands out: OSMA members are vitally concerned about the future of medicine.

Because the OSMA wants to continue to monitor these concerns — your concerns — you may be asked at some time in the future to participate in a Focus Group Interview. Please accept. **Our** caucuses have a lot less smoke than the politicians and a lot less hot air, but they **are** just as important.



the osma committees

The Communications Network

The Focus Group Interviews, or any of the Communications work of the OSMA, would not be possible without the hard-working Communications Committee.

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Mrs. H. William Porterfield, M.D., Columbus

The committee meets regularly to oversee current communication projects and to consider and recommend new projects to help improve the communication efforts of the OSMA. All activities are then carried out by the OSMA Department of Communications.

Since the committee is responsible for directing all internal and external communication activities for the Association, it is a complex and time-consuming task. To make certain members are aware of the issues facing medicine and of the activities of the Association, the OSMA Journal and OSMAgram are published monthly. A Journal subcommittee of the Communications Committee, chaired by Dr. Wiggin, helps provide physician input to the communications staff in selecting topics and potential authors for Journal articles.

The committee also takes very seriously its charge of communicating to the public on behalf of Ohio physicians.

Aside from Synergy, the OSMA's health education newspaper, the committee oversees numerous other activities to help improve physician image. For example, at present, a subcommittee chaired by Dr. Davies is developing a model media program involving radio, television, newspaper and the community which can eventually be implemented throughout the state. Another subcommittee, chaired by Dr. Smith, is looking into the development of a question-and-answer health column for Ohio newspapers. In addition, the committee reviews all public service announcements distributed by the Association.

All committee members feel very strongly that good communication efforts are vital for a strong association. It welcomes the ideas, suggestions and concerns of any OSMA member.

Carol Wright Mullinax



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THE Ohio STATE Medical Journal
(ISSN 0030-1124)

Features

The Special Problems of Informed Consent 639

William E. Hunt, M.D.

Informed consent becomes a complex issue when "noninformable" patients, such as children, demented, or unconscious patients are involved. A Columbus neurosurgeon examines the complexities, and possible solutions, to such problems.

Risk Management 645

Robert S. Post, M.D.

Liability is becoming an ever-increasing concern for hospitals. This article, by a Cincinnati physician, takes a look at a new position created to handle such concerns.

Teamwork: The 1981 Outstanding Team Physician Awards 649

Robert D. Clinger, M.D.

Six physicians received this year's Outstanding Team Physician Awards. Profiles of all six are included.

AMA Policy on Physician's Assistants 655

Definitions, terms, and functions of physician's assistants are explored in this synopsis of an AMA policy report.

Our Cover

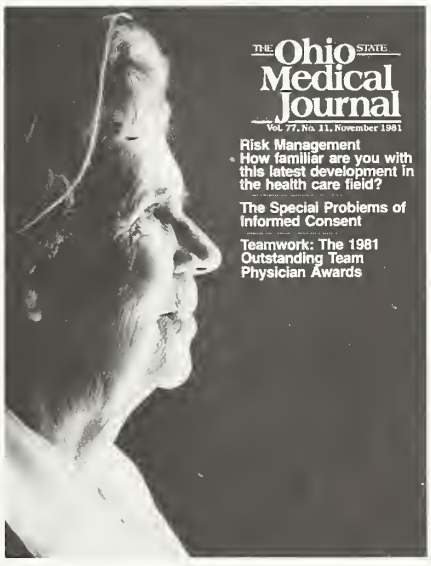
"Pleasant Shaker Thoughts" was one of this year's Outstanding Entries in the OSMA Journal Photographic Contest. The photo was taken by Judith Weidenthal, Pepper Pike, a first-time entrant in the contest. Her photo "Condo Points," which also took an Outstanding Entry, appeared on The Journal's August cover.

Team Physician Award Recipients





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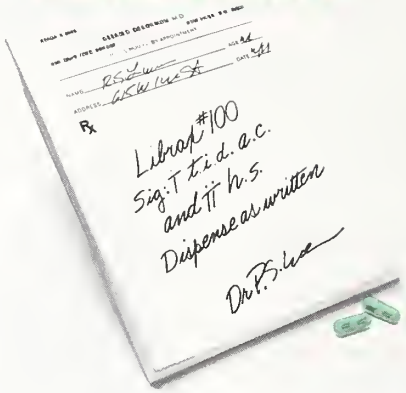
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Cincinnati pediatrician recipient of Francis Award

DAVID VANGINKEL, M.D., Cincinnati, is the 1981 recipient of the Francis Award, presented by the Friars Club for distinguished service to youth. Dr. VanGinkel, a pediatrician, recognized for successfully persuading the Cincinnati Pediatric Society to sponsor and conduct the Head Start Program. He also was cited as a principal force behind the reorganization of the East End Health Care Center.

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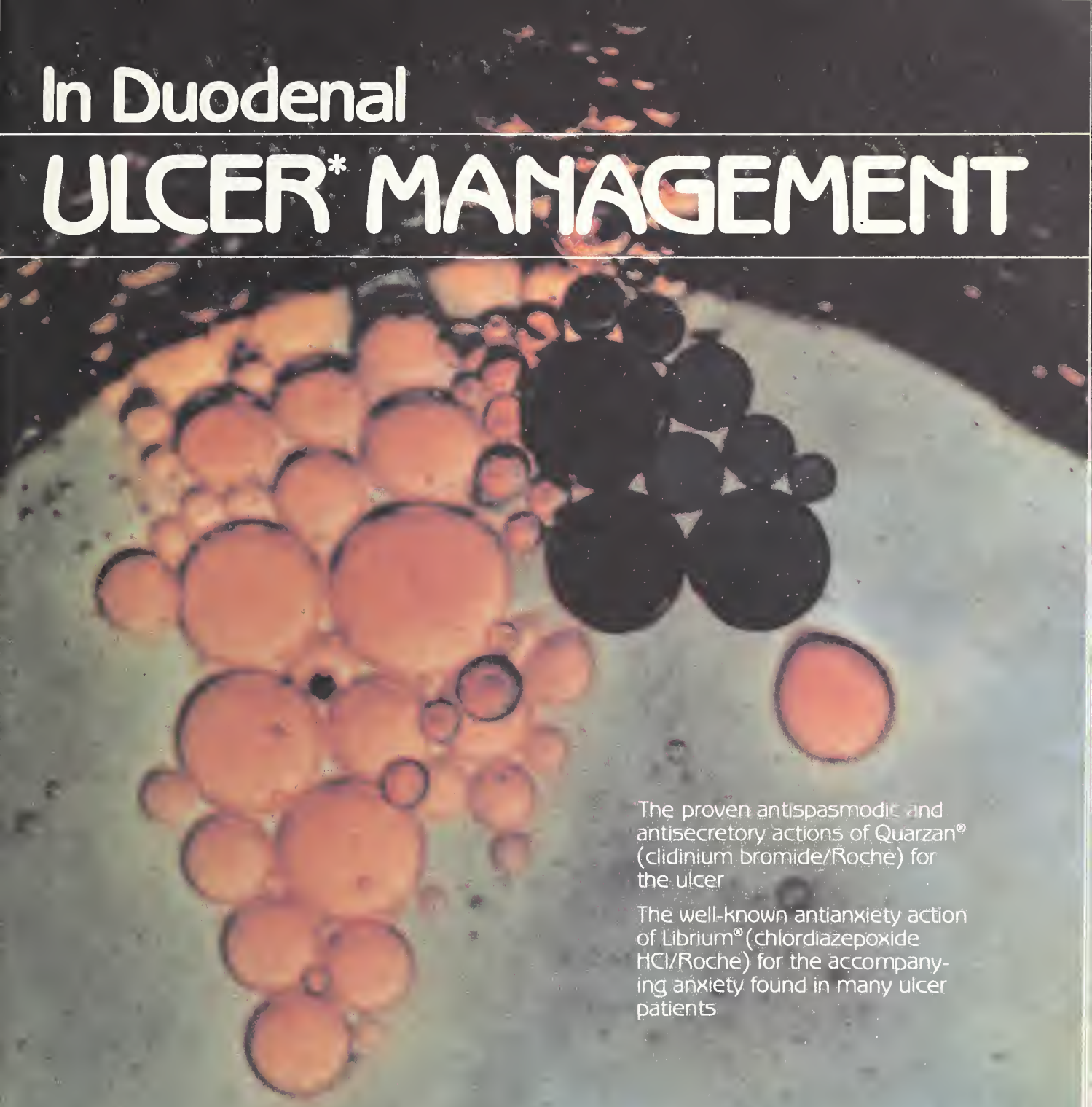
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Photograph of simulated gastric hypersecretion.

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PS Form 3526, June 1980 (Page 1)

COLLEAGUES IN THE NEWS

JOHN R. BELJAN, M.D., Dayton, was named provost of Wright State University. Dr. Beljan formerly served as the university's vice president for health affairs and as dean of the school of medicine.

A bronze plaque was installed in the Butler County Courthouse in memory of **GARRET J. BOONE, M.D.,** coroner. The plaque, which was designed by Dr. Boone's son, includes a likeness of Dr. Boone superimposed on a map of the county and reads: "To one who gave so much to so many for so long. We, the citizens of Butler County are forever grateful."



Larry C. Carey, M.D.

LARRY C. CAREY, M.D., Columbus, was elected president of the Ohio Chapter of the American College of Surgeons.

ALVIN H. CRAWFORD, M.D., Cincinnati, was promoted to professor of orthopedic surgery at Children's Hospital Medical Center. Dr. Crawford also was elected national chairman for the Orthopaedic Section of the National Medical Association.

WILLIAM GATES, M.D., Cincinnati, has been appointed to the State of Ohio Emergency Medical Services Advisory Council which serves as an advisory board to the Governor. Dr. Gates also serves as chairman of the Committee on Emergency and Disaster Medical Care for the Ohio State Medical Association.

JOHN A. HUDEC, M.D., was elected chief of staff at Deaconess Hospital, Cleveland. **ISIDRO J. AMIGO, M.D.,** was elected vice chief of staff, and **GENE BOYCHUK, M.D.,** secretary-treasurer.

WILLIAM R. JOHNSON, M.D., Youngstown, was named clinical director of emergency services at St. Elizabeth Hospital Medical Center. Dr. Johnson is assistant director of the department of internal medicine at St. Elizabeth's and is an assistant professor of internal medicine at the Northeastern Ohio Universities College of Medicine.

ROBERT W. JONES, M.D., Mansfield, was appointed vice president for medical affairs at Mansfield General Hospital. Dr. Jones, now retired, is the founder of Mansfield Internists, now a five-physician medical practice on Cline Avenue.

RICHARD W. JUVANCIC, M.D., Girard, was named coordinator of medical education at Youngstown Hospital Association. Dr. Juvancic serves on the Family Medicine Review Subcommittee of the Ohio Academy of Family Practice and is an associate professor of family medicine at Northeastern Ohio Universities College of Medicine. He is a member of numerous professional organizations and has authored many publications and papers.

WILLIAM K. LEE, M.D., Cardington, was named medical director of the Morrow County Health Department. Dr. Lee is in private practice and currently serves on the Cancer Society Board.

ASIKIN MENTARI, M.D., Cleveland, was named director of physical medicine and rehabilitation at St. Alexis Hospital.

GALE W. MILLER, M.D., Cincinnati, was appointed director and associate professor of otology and neurotology at the University of Cincinnati College of Medicine.

ROBERT REYNOLDS, M.D., Lakewood, was named vice president of the American Heart Association Northeast affiliate.

DALE A. SOLZE, M.D., Fremont, was reappointed to the Medical Advisory Committee of the Ohio Society to Prevent Blindness.

continued on page 673



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Obituaries

EDWARD ALBERTS, M.D., Cincinnati; University of Nebraska College of Medicine, 1930; age 72; died December, 1978; member OSMA and AMA.

EMMETT ARNOLD, M.D., Greenville; Ohio State University College of Medicine, 1929; age 76; died August 19, 1981; member OSMA and AMA.

F. X. BAURICHTER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1930; age 76; died December, 1979; member OSMA and AMA.

FRANK H. BLY, M.D., Akron; Ohio State University College of Medicine, 1925; age 80; died July 16, 1979; member OSMA and AMA.

ROBERT H. CHESS, M.D., Cincinnati; Meharry Medical College School of Medicine, Nashville, Tennessee, 1959; age 51; died July 19, 1981; member OSMA and AMA.

HAROLD G. CURTIS, M.D., Cleveland; Case Western Reserve University School of Medicine, 1930; age 75; died September 5, 1981; member OSMA and AMA.

BERMAN S. DUNHAM, M.D., Toledo; Wayne State University School of Medicine, Detroit, 1916; age 94; died August, 1981; member OSMA and AMA.

DANIEL E. EARLEY, M.D., Cincinnati; University of Cincinnati College of Medicine, 1932; age 75; died August 26, 1981; member OSMA and AMA.

WILLIAM J. FORNES, M.D., Cleveland; St. Louis University School of Medicine, 1931; age 76; died August 4, 1981; member OSMA and AMA.

LAWRENCE GOLDBERG, M.D., Athens; Ohio State University College of Medicine, 1944; age 68; died September 13, 1981; member OSMA.

RICHARD LOUIS HAAS, M.D., Dayton; St. Louis University School of Medicine, 1936; age 69; died September 1, 1981; member OSMA.

VIRGIL HAUENSTEIN, M.D., Cincinnati; University of Cincinnati College of Medicine, 1935; age 74; died August 7, 1981; member OSMA and AMA.

FRED S. KOPPEL, M.D., Cleveland; University of Freiburg, Germany, 1914; age 90; died August 14, 1981; member OSMA and AMA.

MARION N. MALINOWSKI, M.D., St. Clairsville; University of Innsbruck, College of Medicine, Innsbruck, Austria, 1950; age 68; died August 28, 1981; member OSMA and AMA.

DONALD E. MILLER, M.D., Milford; Ohio State University College of Medicine, 1951; age 61; died August 31, 1981; member OSMA and AMA.

ROBERT W. MUEMZER, M.D., Toledo; University of Michigan Medical School, 1944; age 61; died August 27, 1981; member OSMA and AMA.

ALBERT M. PFEFFER, M.D., Cleveland; Creighton University School of Medicine, Omaha, 1920; age 90; died July 21, 1981; member OSMA and AMA.

SIDNEY H. SACHS, M.D., Cleveland; University of Maryland School of Medicine, Baltimore, 1947; age 56; died July 31, 1981; member OSMA and AMA.

FRED E. SPANGLER, M.D., Lancaster; Ohio State University College of Medicine, 1935; age 72; died September 4, 1981; member OSMA and AMA.

THOMAS R. SOEHNLEN, M.D., Navarre; St. Louis University School of Medicine, 1955; age 54; died August 3, 1981; member OSMA and AMA.

FRANCIS M. STEPHENS, M.D., Cincinnati; Ohio State University College of Medicine, 1930; age 79; died May, 1981; member OSMA and AMA.

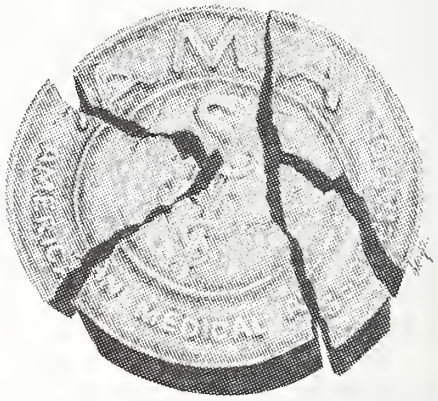
SAMUEL N. ULEVITCH, M.D., Rancho La Costa, California; Medical College of Wisconsin, Milwaukee, 1932; age 73; died September 4, 1981; member OSMA and AMA.

RICHARD W. WEISER, M.D., Jewett; University of Pennsylvania School of Medicine, 1927; age 79; died August 14, 1981; member OSMA and AMA.

WILLYS L. WOODWARD, M.D., Toledo; New York Medical College, New York, 1949; age 57; died August, 1981; member OSMA and AMA.

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ECOND OPINION

Problem Patients Are Made, Not Born

By Robert D. Gillette, M.D.

"Over time, it has become clear that (problem patients) do not come into being by spontaneous generation, nor are they creatures of a malevolent deity who hate doctors . . . to a significant extent, we physicians create them ourselves."

In two decades as a family doctor, I have cared for my share of problem patients: those with multiple symptoms for which no organic cause can be found; the ones who regularly call in the middle of the night for apparently trivial reasons; and all the other familiar subtypes. Over time it has become clear that these people do not come into being by spontaneous generation, nor are they creatures of a malevolent deity who hate doctors. Cultural, economic and genetic factors may contribute to the origin of such behavior patterns, but to a significant extent we physicians create them ourselves.

If that statement sounds rash consider the history of a recent patient, typical of many we have all seen. As a child she suffered from recurrent asthma. Her mother, following their doctor's advice compulsively, kept her at home at the slightest sign of a cold and sharply limited her social life. She went away to college, was unable to adapt socially and became depressed. A physician told her she had "mono" and abetted her decision to drop out. She married, made a poor sexual adjustment and developed pelvic congestion syndrome. This was "solved" with a hysterectomy. After surgery she gained weight rapidly and underwent a futile weight-reduction program which included prescribed amphetamines. Now she is facing the normal stresses of middle age and is so accustomed to sick role behavior that she resists any attempt to work with her constructively. She is a problem patient, and the medical profession helped to make her that way. A problem patient is one whose problems, although presented as "medical," are not relieved by "medical" measures, causing the physician to feel frustrated or angry. The practitioner's discomfort is an essential part of the diagnosis.

The result could have been different if her doctors had been attuned to human behavior and had responded appropriately. The physician who managed her childhood asthma might have recognized and dealt with the feelings of guilt and inadequacy that parents often feel in this setting, and with the overprotection that often results. Her adolescent depression could have been recognized and treated with understanding and support; today we might also prescribe a tricyclic antidepressant. Her pelvic congestion syndrome should have led her physician to search, in a gentle and understanding manner, for sexual problems and their roots in the pressures of her life.

Do these recommendations sound unrealistic? For many of today's practitioners they are. Most of us received our medical education in a system which taught much about diseases but little about the people who have them. We were criticized for not knowing medical facts or for

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forgetting to order certain tests, but failure to understand our patients or to treat them in a humane way was often overlooked. The situation is getting better but there is still room for improvement. Even today most medical graduates learn to be well-rounded, empathetic physicians by trial and error.

Many subspecialists argue that the management of these patients does not fall within their area of expertise and is not their responsibility. For example, most orthopedic surgeons prefer not to manage psychogenic backaches. That's okay, but they have an obligation to avoid unnecessary myelograms and back braces and to encourage patients to get help in dealing with their tensions. This is the only course consistent with the time-honored dictum, "First, do no harm." Patients won't always accept such advice when it's offered, but in my experience many will seek help in time if the explanation is presented in a kind, informative way.

"Alert doctors can often take steps to keep little psychological problems from developing into big ones."

Alert doctors can often take steps to keep little psychological problems from developing into big ones. Is there a child in your practice whose parents are always belittling him? Maybe you can help them break that habit, or at least help the child to feel better about himself. Are you treating a patient with vague but persistent abdominal complaints? Perhaps you can help her see the relationship between her symptoms and the pressures in her life, or refer her to someone who can. Does one of your patients keep coming back with complaints that are clearly a cover for loneliness? Seeing this patient for five or ten minutes once a month might, in the long run, be most economical of the patient's time and your energy. Doctors often say that time pressures won't let them follow these recommendations. I don't have hard data to prove it, but experience has convinced me that in the long run you save time by evaluating the behavioral components of your patients' problems as thoroughly as the organic aspects. Nothing is so wasteful of the doctor's time and the patient's money as failure to get to the bottom of psychogenic problems. Redundant searches for organic disease overload our hospitals and raise the cost of health insurance. Patients sloughed off by one practitioner wind up on the doorstep of another in a futile revolving-door process. It all reminds one of the sign in the back room of a plumbing shop: "If you can't find time to do the job right, how are you going to find time to do it over?"

Ultimately, the responsibility for producing humane physicians lies in the medical education system. Every group of medical students includes people with the potential to become compassionate, highly motivated "people doctors."

Better ways must be found to educate these students without destroying their warmth in the process. The educational system must include rewards of empathic patient care comparable to those for superior intellectual achievement. The definition of clinical excellence must include the understanding and management of the psychological, interpersonal and family aspects of health. It is a disservice to patients to overlook organic disease but equally bad to ignore the behavioral aspects of health care. American doctors do a magnificent job with complex medical and surgical problems. If they were as good with the human side of care, however, there would be less need for essays like this one. OSMA

Robert D. Gillette, M.D., Cincinnati, is a member of the OSMA and Associate Professor, Department of Family Medicine, University of Cincinnati College of Medicine.

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NEWS

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edited by Karen S. Edwards

Medical historians may submit papers

Physicians wishing to submit papers for presentation at the Ohio Academy of Medical History meeting, scheduled for April 24, 1982, in Rootstown, Ohio are urged to do so before the January 31st deadline.

President of the group, Paul G. Dyment, M.D., points out that papers should be limited to 15 minutes, but any subject within the Academy's field of interest will be welcome.

Questions may be directed either to Dr. Dyment, at the Cleveland Clinic (216) 444-5518, or to Patsy Gerstner, M.D., Secretary-Treasurer, who can be reached at the Academy's offices: 11000 Euclid Ave., Cleveland, Ohio 44106, (216) 368-3648.

Retirement no longer reason for dues exemption

AMA members who are over age 70 and retired from practice and those experiencing financial hardship will continue to be exempt from dues, but retirement alone has been eliminated as a cause for dues exemption.

The Board of Trustees, following action of the House of Delegates at the 1981 Annual Meeting, established new standards and procedures for the granting of dues exemptions. The standards will not be applied retroactively to members who are now dues exempt, the board noted.

Under the old criteria, there was no age limitation in the retirement dues-exempt classification.

In addition to eliminating the retirement category, the board:

• Defined financial hardship and disability, consistent with the Bylaws, so that the board "may excuse members from payment of dues to alleviate financial hardship or because of forced retirement from medical practice due to physical disability."

• Confirmed house action mandating that any active member over the age of 70 and retired from the practice of medicine won't be required to pay dues to the AMA.

• Confirmed that physicians who reach 70 years of age in 1981 or in subsequent years and are in active practice will be required to pay full regular dues.

• Defined "retired" to be a work load of 20 hours or less per week, which is consistent with other data collection procedures of the AMA.

The house at the 1981 Annual Meeting adopted a board report proposing a revision in AMA dues exempt criteria, and also adopted a report of the Constitution and Bylaws providing the language for the necessary change in the Bylaws.

BOOK SHELF

The Course of Life: Psychoanalytic Contributions Toward Understanding Personality Development. Published by the *National Institute of Mental Health (NIMH).*

Listed as a "major original work on psychoanalytic understanding of human development," this work — compiled into three volumes — provides a broad, detailed look at the scope of human development from the perspective of more than 60 national and international mental health experts.

Volume I focuses on infancy and early childhood; Volume II with latency, adolescence and youth; and Volume III with adulthood and the aging process. The books have been edited by Dr. Stanley Greenspan, Chief, Mental Health Study Center, NIMH, and Dr. George Pollock, Director, Chicago Institute for Psychoanalysis.

The volumes can be purchased from the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

Meetings

Neurology for the Non-Neurologist: December 9-11; Chicago Marriott Hotel, Chicago, Illinois. Sponsor: Rush-Presbyterian/St. Luke's Medical Center. Credit: 20 hours, Category I. Contact: Marilyn Jones, University Office of Continuing Education, Rush-Presbyterian St. Luke's Medical Center, 600 S. Paulina, Chicago, Illinois 60612.

AMA video library continues to expand

The AMA Video Clinic library has currently added two new programs to their existing 17-tape library.

"Primary Care of Common Sexual Problems" and "Chronic Obstructive Pulmonary Disease" are now available through the program which either may be rented or purchased by contacting: The Division of Marketing and Meeting Services, American Medical Association, 535 N. Dearborn, Chicago, Illinois 60610.

Two reports clear Bendectin

Bendectin was given a clear bill of health for use by pregnant women in two research reports that appeared in the July 12 issue of the *Journal of the American Medical Association*. There have been some reports linking the drug — commonly prescribed to control nausea in pregnancy — with birth defects.

Jose F. Cordero, MD, of the federal Centers for Disease Control, Atlanta, described a study of birth defects among infants over a 10-year period in the Atlanta area. For the most part, he reported, there was no association at all between Bendectin and birth defects. A slight possible association was found in certain defects, he said, but the statistical relationship was not significant and the implied risk extremely low, if one exists.

The physician added, however, that "Since it is impossible to prove any agent safe, our study should remind physicians that the potential risk of drugs during pregnancy should be weighed against the potential benefits that they may have."

A similar study in the Boston area developed similar results. Allen A. Mitchell, MD, of the drug epidemiology unit at the Boston U. School of Medicine's school of Public Health, sought reports of two types of birth defects — cleft palates and heart defects. Interviews with mothers of 98 infants with cleft palate, 221 with cleft lip, and 122 with selected heart defects failed to reveal any association with taking Bendectin, he said.

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The Special Problems of Informed Consent

By William E. Hunt, M.D.

Editor's Note:
The following text was presented at the Seventh International Congress of Neurological Surgery in Munich, Germany this past summer. The address, delivered by Dr. Hunt, was entitled "Special Problems Concerned with Obtaining Consent from Non-Informable Persons — Children, Demented Patients, Unconscious Patients."

The recent emphasis on informed consent has, in many ways, improved the quality of medical care. An informed public demands and deserves as much information as they can understand.

All of the general principles of informed consent apply to the communications with the immediate family of the child and the demented or unconscious person. We prefer an individualized handwritten note, signed and witnessed, to printed forms. It establishes the fact of personal contact. We use the word "request" rather than "consent." The surgeon who obtains a "request for operation" from the patient rather than a "consent for operation" has a more trusting and cooperative relationship with his patient. It is useful to state that an opportunity for questions was offered. The process is identical to that employed with the rational adult.

Special problems arise in the incompetent, however:

1. Responsible relatives or guardians may not exist, or an emergency situation may make it dangerous to delay the operation.

In such circumstances the surgeon should obtain consultation, if possible. His recorded opinion that the procedure is absolutely necessary for the welfare of the patient should be carefully written, with explanation of his reasoning, and an indication that he is aware of alternatives and of the risks involved. If there is time, as in an elective procedure on such a patient without family or guardian, a hospital administrator or attorney might be involved for the record. If the patient's competence is questionable, due to organic or functional psychosis, and if the procedure is not an emergency, psychiatric opinion is advisable. The law presumes competence in questionable cases. If the record is clear and the professional judgment defensible, there are ordinarily few problems.

"The law presumes competence in questionable cases. If the record is clear, there are ordinarily few problems."

2. The next-of-kin or closest friends may not agree that a procedure, deemed appropriate by the surgeon for the patient's welfare, should be done.

Here, the law usually considers the demented patient and the child to be under the protection of the state. If there is active opposition to the surgeon's recommendation, and if there is time, a court order may be obtained overriding such objections. This principle has been applied in the case of religious sects opposed to blood transfusion and to cases in which the next-of-kin prefer that the patient die, rather than be subjected to therapeutic attempts which may fail or leave the patient disabled and dependent. The court, as the protector of the incompetent, tends to uphold the surgeon's recommendation. A child may not be put at risk because of the religious convictions or desires, expressed verbally or otherwise, of other parties. Retarded patients who have never been competent have been treated as children. In the case of older children, minors but not emancipated, common sense dictates that such a patient be as informed as possible, in the judgment of the surgeon and that this be documented.

3. In the case of a demented or comatose patient, another problem may arise if he or she has expressed, while competent, the desire to be allowed to die under some circumstances.

This has produced controversy and divided opinion, since the chance of recovery from various conditions is relevant, and may not have been fully understood by the patient. The principle is that the law can protect the patient against other persons, but is reluctant to override what the patient might be presumed to have wanted when competent, if there is clear evidence of those wishes.

4. Lastly, recent court decisions in California indicate that the next-of-kin may not be legally authorized to sign a consent or request for surgery unless there exists a previous power-of-attorney signed by the patient.

The latter, of course, rarely exists. This creates an impossible dilemma and makes the physician a target for suit on the "informed consent" issue alone. I am told that California Hospital Association attorneys have developed a form requiring the signature of the surgeon as the responsible person authorizing the surgery as an "emergency," even in cases where the operation has been scheduled electively for days or weeks. The effect of such maneuvers on the intent of the law is questionable.

In summary:

1. In emergency cases the surgeon must assume the full burden of the decision to operate.

2. In elective cases, next of kin must be informed as if they were the patient (this doctrine, as noted, has been questioned in one state).

"Expressed opinions of a previously competent person are given serious consideration in our courts."

3. If the next-of-kin disagrees, the surgeon may need a judicial decree to carry out what he perceives as his obligation to the patient. The state is perceived as the protector of the incompetent or child.

4. Expressed opinions of a previously competent person are given serious consideration in our courts.

5. The legal situation is a tangle of contradictions at present. Each state is different — some have no laws, and there is variation among states in which there are laws. The final defense against litigation is that the quality and appropriateness of the care rendered, well documented and humanely considered, will persuade judge and jury of the propriety of the course of action taken by the surgeon. OSMA

William E. Hunt, M.D., Columbus, is a member of the OSMA, and Professor and Director of the Division of Neurologic Surgery at the Ohio State University.

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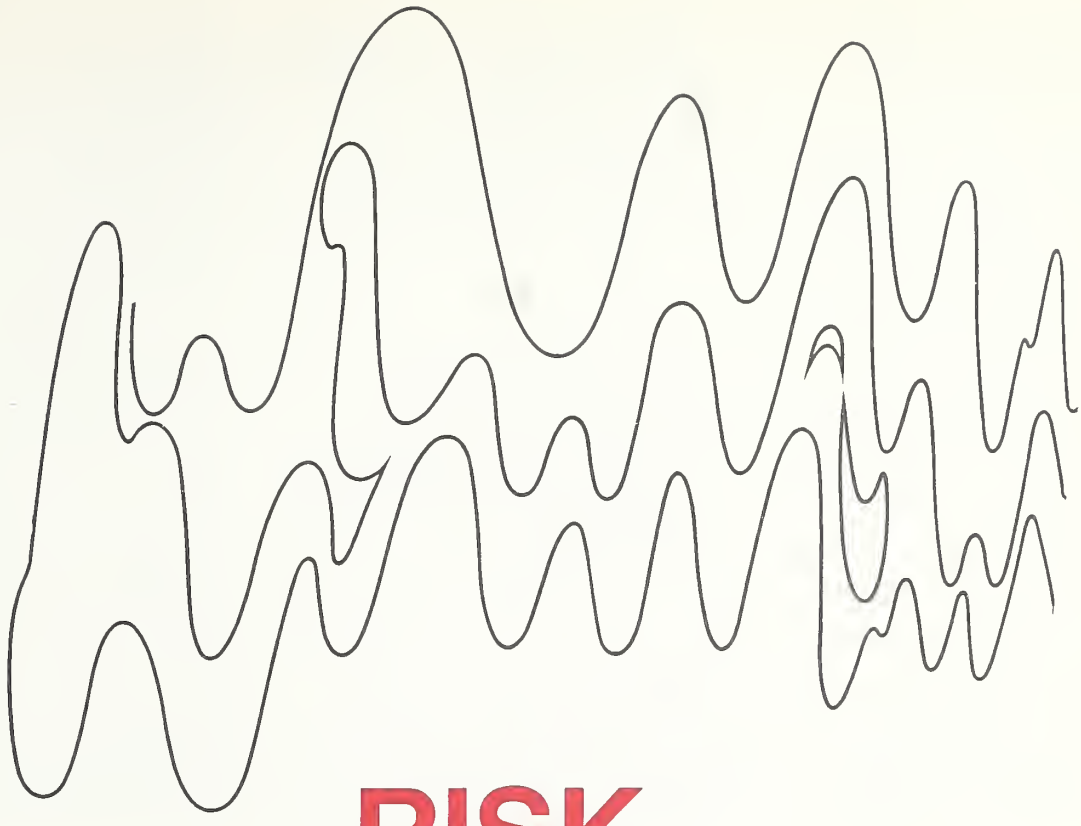


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RISK Management

By Robert S. Post, M.D.

When a hospital patient experiences an unanticipated injury, it's the risk manager who now steps in for a look at the problem.

The risk manager was a relative unknown in hospitals until the early 1970s. A combination of gradually escalating numbers of claims, increasing sizes of awards and a severe decline in the stock market created a crisis in the insurance industry. Physicians found malpractice insurance premiums to be exorbitant, indeed if insurance was available at all. "Going bare" was seriously considered by many and actually done by some. Court decisions found hospital corporations liable for acts of their medical staff and the "ostensible agency" theory extended trustee's liability to include those areas run under contract service such as the emergency room. Boards of trustees were forced to take a closer look, not only at their increasing cost for insurance coverage, but at their expanding liability. They, too, considered self insuring or forming their own insurance companies, and some did.

As part of the package offered by insurers, a variety of claim services had always been available. Incident reports were encouraged, and statistics relating to these generated. Inspections were conducted to assess fire and safety hazards. Numerous educational efforts were encouraged for all levels of staff and prepared programs offered. Most of these services were not enthusiastically accepted by the hospitals, and physicians were rarely actively involved, despite their key role in many liability problems. It became obvious that a more intensive, in-house effort was needed.

The factors and forces outlined above clarified the need for some internal hospital structure to facilitate the definition and description of these problems, document their frequency and attempt their management. Logic dictated that someone with claims experience and a practical knowledge of the law, the hospital and the hospital staff functions should be involved when a patient experiences

an unanticipated injury. Hospitals began to employ persons in this capacity or delegate such responsibility. The function was termed risk management.

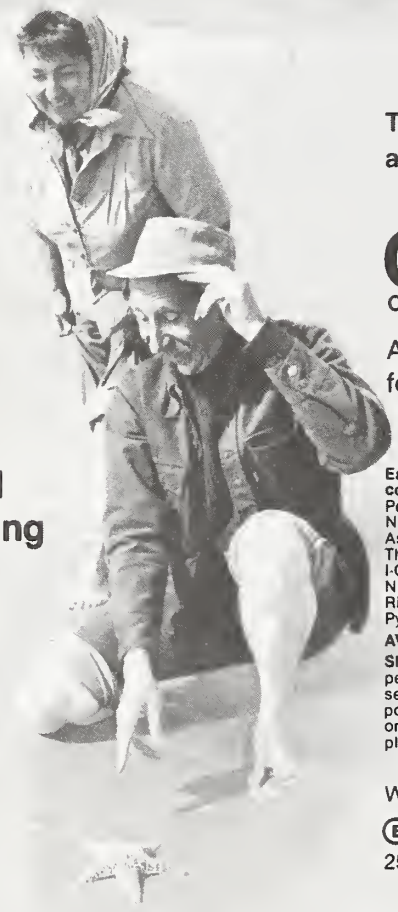
The designation of an individual to assume the management responsibility for all such events permits him or her to gain the experience and develop technics which not only protect the patients and staff in such situations but which can diminish the costs related to such liability issues. The risk manager's function is to remain objective; to facilitate communications among all parties; secure write-offs of charges if indicated; represent the hospital to irate patients; evaluate the chart for appropriate documentation; secure legal advice if needed; and perform a variety of other tasks which can well influence the outcome of a given problem. A follow-up investigation by the risk manager documents at the time exactly what happened, rather than relying on recollections dulled by time and subconscious suppression.

The risk manager must be aware of untoward events in order to function effectively. His services may not be required but a knowledge of such events is mandatory if there is to be some systematic problem-detecting and solving system established. Only by collecting, sorting and evaluating these events can patterns or trends be detected and steps taken to prevent their occurrence. The perfect system would prevent all such happenings and do away with the requirement for the management function.

"The risk manager's function is to remain objective; to facilitate communications among all parties."

The risk manager has relatively little authority in dealing with medical liability problems. His function is one of advising and recommending based upon knowledge and experience gained. If his advice is not followed and time proves that it should have been, then the appropriate authority-possessing bodies must take action. Hence, communication skills are mandatory and confidence must be engendered in all professional and nonprofessional staff. His role is not to criticize retrospectively but rather to assist all in finding the best way out of a difficult situation and use that particular experience to attempt to prevent a recurrence through a systems change or education.

The pressures of the 1970s upon the medical profession's real or alleged liability risk have not gone away. The frequency of claims continues to increase and new records for jury awards are set almost monthly. The medical profession and the hospitals now are finding themselves burdened with yet another social welfare cost for



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which society cannot find an equitable solution.

Iatrogenic events have always plagued the health care provider; and, in addition, one cannot interfere with the biologic process, whether normal or abnormal, without occasionally experiencing unexpected results. The outcomes of this combination of human frailty and biologic complexity were at one time accepted in an understanding if not fatalistic way by the public seeking medical care. The era of consumerism coupled with overzealous reporting of medical miracles have led the public to expect perfection and more and more any untoward event or result in the medical care setting, no matter how minimal, appears to be just cause for an attempt at financial remuneration. These events occur in all institutions with considerable frequency. It is unusual that true negligence is responsible as would be defined by a panel of medical peers, but a panel of lay persons might judge otherwise. Thus, a nosocomial wound infection might be considered to be the result of negligent care despite an irreducible incidence of such events in the best-controlled environment.

The medical profession must understand the significant nature of the current problem. It is assuming the proportions of a serious socioeconomic dilemma which cannot be solved within the medical profession alone. Steps can be taken to minimize the risk for individual hospitals and health care professionals but the larger issues must be solved within the political arena. The risk manager at the present time offers an approach to the problem which deserves the attention and cooperation of every medical staff member. If you have one, get to know him. If you don't, find out what your hospital's liability experience is. Perhaps you and your hospital might benefit from such services. OSMA

Robert S. Post, M.D., an OSMA member, is the Coordinator of Professional Affairs for the University Hospitals of Cleveland.

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The 1981 Outstanding Team Physician Awards

By Robert D. Clinger

Six physicians received Ohio's Outstanding Team Physician Awards presented by the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association and the Ohio High School Athletic Association.

The awards were presented this past summer in Canton, Ohio, and recipients were:

Philip N. Gilcrest, M.D., Doylestown

Dr. Gilcrest began his duties as team physician for Chippewa High School shortly after establishing his family practice 25 years ago. Since then, he has become actively involved not only in the school's athletic program, but on the local board of education as well, serving as a member of the board for 16 years.

"Dr. Gilcrest is well respected professionally, and personally liked by those who have come in contact with him," says Owen W. Logee, M.D., of Wooster, secretary-treasurer of the Wayne County Medical Society. "He indicated that his involvement in local athletics was merely another part of his job of serving the community for which he deserved no special recognition. (But) his extra efforts over the years obviously have been above and beyond those of the average physician."

Robert J. Kuba, M.D., Uhrichsville

Dr. Kuba first became involved in sports medicine in 1953 in East Canton. He later moved to Dennison and spent six years there as high school team physician, until the consolidation of Dennison and



Dr. and Mrs. (Irene) Philip N. Gilcrest of Doylestown.



Dr. and Mrs. (Dorothy) Robert J. Kuba of Uhrichsville.

All photos were taken by Robert D. Clinger



Dr. and Mrs. (Jean) James E. Printy of Sandusky.

Uhrichsville Schools produced Claymont High School in the mid-1960s. Since then, his activities as team physician have centered around Claymont High School.

"His care for the youth before, during and after an event is exceptional," remarks Pastor Albert J. Johnson, Jr., about Dr. Kuba's work as a team physician, and Claymont High School Principal Dan E. Brooks says, "His opinions and medical judgment about athletic injuries are highly respected by the coaches, administration and parents of our athletes."

It's apparent that his work as a team physician is just as satisfying to Dr. Kuba. He recently remarked: "It has always been a source of great satisfaction to me to assure athletes when their injuries are not serious — and to be a part of the rehabilitation for those with more serious injuries."

James E. Printy, M.D., Sandusky

When Dr. Printy is not at work as chief of obstetrics and gynecology at Good Samaritan Hospital in Sandusky, or as chief of gynecology at Providence Hospital, then he is likely to be near the playing fields at Perkins High School where for 26 years he has served as that high school's team physician.

"Dr. Printy is not only an excellent physician in the area of athletic injuries," says Perkin's Principal, Maxwell J. Shoff, "but he also displays many characteristics that are conducive toward development of good educational environment."

Dr. Printy was himself an athlete while attending Georgetown University, and his 12 children have all been active in scholastic sports.

Franklin D. Rodabaugh, M.D., Bluffton

"One of the rewards of family practice, after delivering babies, is to follow them as they develop and mature," says Dr. Rodabaugh — and he should know. For 35 years he's watched his young patients grow up, and some of them participate on the Bluffton High School Football Team, for which he serves as team physician.

"He has served without pay — sacrificing his weekends when he was already burdened by an exhausting schedule, typical of a general practitioner in a small community," says Charles D. Buroker, superintendent of the Bluffton Exempted Village Schools.

Although elected to the Bluffton College Football Hall of Fame in 1977, Dr. Rodabaugh probably received his highest compliment from Carlin B. Carpenter, director of athletics, and head football coach at Bluffton College when he recently said:

"If there is a person more deserving of the award than Dr. Rodabaugh, God bless him, for he is truly a saint."

Kenneth Rupp, M.D., Streetsboro

Dr. Rupp has been more than a family practitioner and team physician for the Streetsboro High School



Dr. and Mrs. (Lois) Franklin D. Rodabaugh of Bluffton.



Dr. and Mrs. (Evelyn) Kenneth F. Rupp of Streetsboro.



Dr. and Mrs. (Bonnie) Luis A. Vazquez of St. Clairsville.

football team these past 23 years. His activities in the community never seem to cease.

He has served as a volunteer fireman; taught first aid classes and underwater rescue techniques; and has served on the Streetsboro Board of Education, the Portage County Mental Health Board and on the board of Alpha Enterprises, an organization for the handicapped.

"He is an institution in our community," says James R. Sikler, Streetsboro City Schools Superintendent. "Most of the time he is the only physician on the field, even at away games. He ministers to players on the other teams as well as our own. It is difficult to imagine how he could donate the amount of time and effort, totally without compensation, that he has donated to the young people in our schools."

Luis A. Vazquez, M.D., St. Clairsville

A family practitioner as well as a general surgeon, Dr. Vazquez finds it difficult to suppress his satisfaction with his job as team physician for St. Clairsville High School.

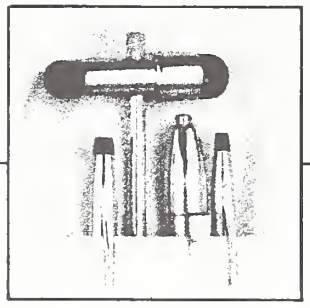
"There is not a word to describe my feelings. I love kids. They make me feel young. I wish that I would spend another 20 years with them."

His "love of kids" has made him push hard in the area of student athletics. A strong advocate of certified athletic trainers at the high school level, his persistence prompted the Joint Advisory Committee on Sports Medicine to adopt his motion to add a certified high school athletic trainer to the Committee.

"Dr. Vazquez is a family man's practitioner," sum up the people who work with him. "He really cares and is concerned for the health of all to whom he ministers." OSMA

Robert D. Clinger is a contributing editor of the Ohio State Medical Journal.

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AMA Policy on Physician's Assistants

DEFINITIONS AND TERMINOLOGY

In 1970, the House of Delegates endorsed the following "working definition" of a physician's assistant:

"A skilled person qualified by academic and practical on-the-job training to provide patient services under the supervision and direction of a licensed physician, who is responsible for the performance of that assistant."

PA FUNCTIONS

In accordance with the "Guidelines for Development of New Health Occupations," job descriptions for physician's assistants in the areas of primary care and surgery have been prepared by the appropriate medical specialties and approved by these groups and the AMA.

In addition, the following statement relating to functions of the physician's assistant was adopted in 1977 by the AMA's House of Delegates:

A physician's assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the PA's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician's assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician's assistant, the qualifications and experience of the supervising physician, a description of his or her practice; a description of the manner and the health care settings in which the assistant will be utilized and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician's assistants that the physician or group of physicians plans to employ and supervise.

A physician's assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board.

The Task Force studying this issue further recommended that state medical licensing boards, in their review of applications for utilization of a physician's assistant, take special care to insure that the PA functions proposed not be of a type which (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician's assistant, or (c) would authorize the unlicensed practice of medicine.

PHYSICIAN SUPERVISION

In 1979, the Task Force recommended adoption of the following statement:

The physician's assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician's assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician's assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times.

The physician's assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home.

The state medical licensing board should determine on an individual basis the number of physician's assistants that a particular physician may supervise or a group of physicians may employ.

FUNCTIONS OF PHYSICIAN-EMPLOYED PAs IN HOSPITALS

The Association has stated that it is appropriate for PAs to provide services to the hospitalized patients of a physician employer, under the direction of that employer, if hospital policy permits it.

HOSPITAL EMPLOYMENT OF PHYSICIAN'S ASSISTANTS

While it is preferable and desirable

that the physician's assistant be employed by a physician or group of physicians, where a physician's assistant is employed by a hospital, the physician's assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff, and under the direction and supervision of a designated physician.

PRESCRIBING BY PHYSICIAN'S ASSISTANTS

With specific reference to using physician's assistants to make medical judgments as to the drug of choice for a particular patient without the concurrence of a physician or the imposition of careful controls, the AMA does not believe that this function can be delegated to physician's assistants safely or with assurance that the medical needs of the patient will be competently met.

CERTIFICATION OF PAs

In 1971, the AMA endorsed the concept of a national certification program for the physician's assistant. Implementing this action, the Association cooperated with the National Board of Medical Examiners in development of a national proficiency examination for the assistant to the primary care physician, and worked to establish an independent National Commission on Certification of Physician's Assistants (NCCPA). The Commission now certifies those PAs who successfully complete the primary care examination (administered annually) and who meet other criteria, and is studying how to extend certification to PAs working in other specialty areas.

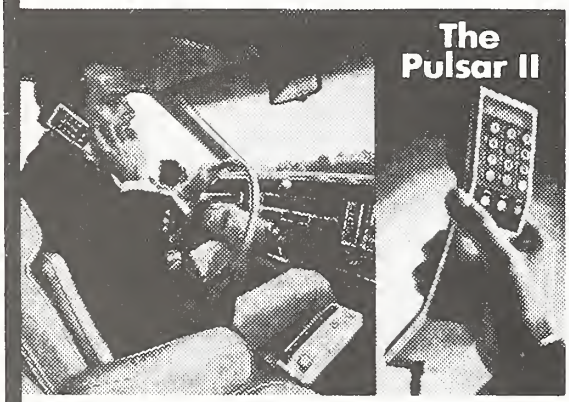
REIMBURSEMENT

The AMA recommends that reimbursement for services of a physician's assistant, employed by a physician, be made directly to the employing physician, including services provided by a PA in a setting remote from the employing physician.

STATE VERSUS NATIONAL REGULATION

The AMA has emphasized in testimony before Congress and in other statements that regulation of health professions and occupations, including the PA, should be the prerogative of states and not the federal government, and that any national legislation in this area, should not usurp this state prerogative to set standards concerning the functioning of such personnel. OSMA

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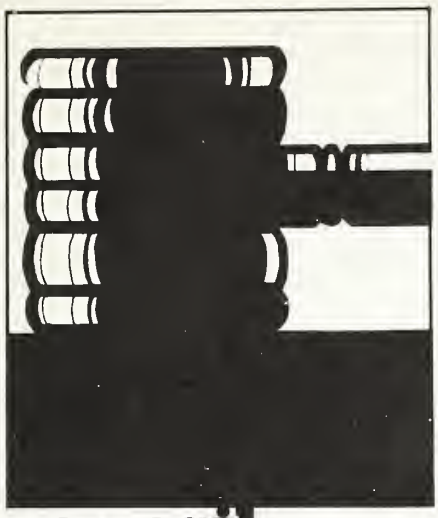
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council proceedings

PROCEEDINGS OF THE COUNCIL

September 12, 1981

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, September 12, 1981, at the OSMA Headquarters, 600 South High Street, Columbus, Ohio.

Those present were: Stewart B. Dunsker, M.D., Cincinnati; Robert G. Thomas, M.D., Elyria; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; Benjamin H. Reed, M.D., Delta; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; A. Burton Payne, M.D., Ironton; David James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; Joseph P. Kloss, M.D., Akron; John H. Budd, M.D., Cleveland; Oscar W. Clarke, M.D., Gallipolis; W. J. Lewis, M.D., Dayton; John H. Ackerman, M.D., Director, ODH, Columbus; James E. Pohlman, Esq., Columbus; Thomas Helmrath, M.D., Columbus; and Ralph Preston, Esq., Columbus.

Those present from the OSMA Staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Katherine E. Wisse; D. Brent Mulgrew; Rebecca J. Doll; Robert E. Holcomb; Gail E. Dodson; Richard A. Ayish; David C. Torrens; Carol W. Mullinax; David W. Pennington; Eric Burkland; Michael L. Bateson; and Louis N. Saslaw.

Announcements by President Dunsker

The Council was called to order by Dr. Dunsker who introduced Thomas Helmrath, M.D., Vice Chancellor of Health Affairs, Ohio Board of Regents.

Dr. Helmrath addressed the Council with regard to current developments in medical education and concerning Ohio health manpower problems.

Dr. Dunsker announced the following appointment of a Committee on Association Structure: John E. Albers, M.D., Chairman, First District; Herman I. Abromowitz, M.D., Second District; Alford C. Diller, M.D., Third District; Richard J. Wiseley, M.D., Fourth District; Edward G. Kilroy, M.D., Fifth District; J. James Anderson, M.D., Sixth District; James Cottrell, M.D., Seventh District; Carl E. Spragg, M.D., Eighth District; John A. Mayer, M.D., Ninth District; J. Hutchison Williams, M.D., Tenth District; James W. Wiggin, M.D., Eleventh District; W. Paul Kilway, M.D., Twelfth District.

Dr. Dunsker referred to the Task Force on Professional Liability a suggestion that a video tape education program on malpractice prophylaxis, similar to that developed in Oregon, be instituted in Ohio.

Four additional Councilors were added to the OSMA Task Force on Professional Liability — Dr. John E. Albers, Dr. C. Douglass Ford, Dr. Joseph L. Kloss and Dr. Carl E. Spragg.

Administration

The minutes of the July 18, 1981 meeting of the Council **were approved** with one change, the substitution of the word "equity" for the word "financial" in the last line of paragraph 2, page 3.

Mr. Page announced the death of Homer Clonch who had been associated with the OSMA since 1974.

Financial and Membership Department

Committee on Auditing and Appropriations — Dr. Pfahl presented the minutes of the September 11, 1981 meeting of the Committee on Auditing and Appropriations.

He moved that there be established by OSMA a wholly owned for profit subsidiary corporation to handle certain new ventures and activities by OSMA. The motion was seconded by Dr. Barr.

The proposal was discussed from the legal standpoint by Ralph Preston, Esq., of the law firm of Porter, Wright, Morris and Arthur.

The proposal **was passed.** (Dr. Abromowitz dissenting)

On recommendation of the Committee, the Council ratified and confirmed the following staff promotions:

Mr. Herbert E. Gillen to Deputy Executive Director.

Mr. David W. Pennington to Director of Government Relations.

Mr. Page was authorized to seek a new staff executive to join the Department of Government Relations.

Other Committee recommendations adopted were:

That the Huntington Investment Management Company be instructed that as currrent instruments mature, funds be invested in short-term U.S. Government securities or in agencies of the Federal Government until approximately 50% of the total on deposit be invested in federally secured instruments.

That an investment of $5000 in a pilot project by Roger Blackwell, Ph.D. to develop demographic data for placement service utilization be approved.

That a Data General C/150 with corresponding disc drive and word processing software and printer be installed at a cost of $97,685 in lieu of upgrading the CS-40 to a CS-70 as previously approved by the Council.

The minutes as a whole **were approved.**

Treasurer's Report —Dr. Barr presented the report of the treasurer and it was accepted for information.

Department of Education & Meeting Management

Committee on Program — Mrs. Dodson presented the July 25, 1981 minutes of the Committee on Program.

The proposed theme for the Annual Meeting "Expanding Horizons: The Wright Way in '82," **was approved.**

A request from PICO for a one-hour program "Update of Medical

Malpractice — 1982" was supported.

The Annual Meeting format was modified to provide for reference reports being available at 9:00 AM and no general program from 9:00 to 11:00 AM on Sunday, May 2, 1982.

Dr. Dunsker pointed out that it might be reasonable to suggest OSMA try the weekend meeting for 3 years prior to compliance with the specifics of Resolution No. 12-81.

The Council voted to introduce a resolution to permit this procedure.

The minutes as a whole **were approved.**

Committee on Education — Mrs. Dodson presented the August 6, 1981 minutes of the Committee on Education. They were accepted for information.

Department of Government Relations

The Department of Government Relations report was submitted in writing and **was accepted.**

OSMA Leadership Conference — Mr. Pennington presented the program for the October 30-31, 1981 OSMA Leadership Conference.

Ambulatory Surgery — Dr. Budd presented an outline of the proposed procedure from Blue Cross of Northeast Ohio for encouraging ambulatory surgery.

It was accepted for information.

Department of Organization Services

Task Force on Professional Liability — Mr. Campbell presented the July 22, 1981 minutes of the OSMA Task Force on Professional Liability.

The minutes were accepted for information.

American Medical Association — Dr. Clarke reported for Ohio's AMA Delegation.

He discussed the question of multiple representation in the House of Delegates. A proposal that OSMA introduce a resolution asking a study of the matter was discussed.

Dr. Clarke announced that the OSMA and its Delegation to the AMA has sent a letter to the AMA supporting Robert M. Zollinger, Jr., M.D., for a position on the American Board of Surgery.

Dr. Lewis discussed the December and June meetings of the AMA and business projected to be transacted at these sessions.

Department of Health Education

Subcommittee on Playoff Coverage — Mr. Gillen presented minutes of the July 23, 1981 meeting of the Subcommittee on Playoff Coverage.

They were received for information.

Subcommittee on Policies and Guidelines — Mr. Gillen presented the minutes of the August 5, 1981 meeting of the Subcommittee on Policies and Guidelines.

The recommendations of the subcommittee members **were approved** as follows:

1. Recommended changes in **Student Participation and Examination Form:**
   a. Label sections on **urinalysis** and **blood count** OPTIONAL.
   b. Add RECOMMENDATIONS to the section on **Abnormal Physical Findings.**
2. Recommended changes in **Annual Questionnaire** (for optional use by junior high schools):
   a. Replace "he" with THE ATHLETE in (1) under **Athlete's History.**
   b. Add RECOMMENDATIONS under **Athlete's History.**
   c. Add space for the reviewing physician to affix his/her signature and the date of the review.
   d. Add the following language at the bottom of the form: IT IS RECOMMENDED THAT THIS REVIEW BE CONDUCTED IN THE PRESENCE OF THE ATHLETE.

The minutes as a whole **were accepted.**

Subcommittee on Impaired Physicians — The minutes of the Subcommittee on Impaired Physicians meeting on August 16, 1981 were presented by Mr. Gillen for information.

Committee on Cancer — Mr. Gillen presented the minutes of the September 2, 1981 meeting of the Committee on Cancer.

Four recommendations of the committee **were approved** as follows:

1. That OSMA agree **in principle** with the **intent** of the language in Representative Edith Mayer's legislative draft — to provide breast cancer patients with necessary information on alternative treatment modalities that are medically viable.
2. That OSMA **oppose legislation** to this effect.
3. That articles outlining conflicting viewpoints on treatment for breast cancer be published early in the upcoming series in the **Ohio State Medical Journal.**
4. That current literature be studied to see if there is an effective publication for physician education — as well as one for patient education. If such publications don't exist, they should be written.

Department of Federal & State Legislation

Mr. Mulgrew discussed a staff document with regard to House Bill 317.

Dr. Payne, Chairman of the Committee on Legislation, discussed committee recommendations concerning the establishment of a Commission on Medical Discipline as a part of House Bill 317.

Such commission would provide physician supervision over the investigative process of the Ohio State Medical Board.

Mr. Burkland reviewed the provisions of House Bill 317.

Dr. Yut moved to postpone definitely, actions on the Committee's recommendations until there is the opportunity to meet with representatives of the Ohio State Medical Board. Dr. Pfahl seconded and **the motion prevailed.**

Mr. Ayish presented the Ohio Legislative report.

Department of Communications

Committee on Communications — Ms. Doll presented the August 26, 1981 minutes of the Committee on Communications.

The Council **approved** a recommendation of the committee that

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a Task Force on Health Care Marketing in lieu of the Communications Subcommittee be established.

The Task Force will develop its charges for Council approval.

Department of Field Service

Mr. Saslaw presented a report on the organization of the Medical Student Section of the Ohio State Medical Association.

He relayed to the Council the request for medical student appointments to OSMA Committees.

The Council **approved** appointments of students to committees with the exception of the Committee on Judicial and Professional Relations, Committee on Auditing and Appropriations and the Subcommittee on Impaired Physicians. (Dr. Yut dissenting)

Mr. Holcomb discussed the 1981 "Fiftieth-year" awards and reported on cooperative programs of business and medicine developed by a number of county medical societies.

Councilor Reports

The Councilors reported on the activities in their respective districts.

Constitution and Bylaws Amendments

Constitution and Bylaws amendments proposed by the Belmont County and the Muskingum County Medical Societies **were approved.**

Legal Counsel Report

Mr. Pohlman reported on the Ohio Supreme Court decision upholding the constitutionality of House Bill 682, The OSMA-sponsored Professional Liability Act.

The Council **approved** the filing of an amicus curiae brief in the Stark County case which is on appeal to the Ohio Supreme Court provided that the case is accepted for decision by the Supreme Court.

Mr. Pohlman discussed an opinion letter from his law firm concerning review of physicians' fees.

The Council voted **to accept** the document for information and to establish an ad hoc committee to study the issue.

A request for the mailing list was considered.

It was agreed that the OSMA mailing list be made available to the Ohio Co. as sales agent for the sole purpose of delivering to the members of OSMA the prospectus of PRORECO common stock offering if such shares are not fully subscribed by PICO shareholders.

Ohio Director of Health

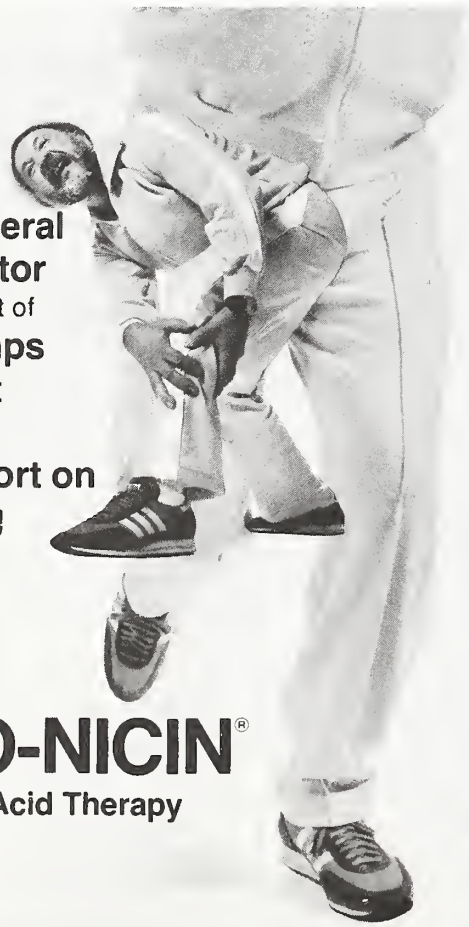
Dr. Ackerman reported increased cases of aseptic meningitis and California encephalitis in the state. He indicated that no influenza or mumps vaccine will be distributed to physicians, nor to health departments by the Ohio Department of Health due to lack of funds.

He will seek elimination of the portion of the law requiring premarital examination for syphilis.

Dr. Ackerman revealed that the Governor has requested the U.S. Department of Health and Human Services to designate Ohio as a single agency state for health planning activity. This would eliminate all HSAs in Ohio and relegate planning to the Ohio Department of Health.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director



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Pyridoxine HCL (B-6) .....10 mg.
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CLINICAL NOTES

Edited by Rebecca J. Doll

This new Journal column will provide updated clinical synopses from a variety of scientific and specialty journals.

Cyclosporin A shows promise in transplants

Preliminary results from clinical trials being conducted at four U.S. medical centers continue to indicate that cyclosporin A may have considerable potential as an immunosuppressive agent in the treatment of renal allograft rejection. A randomized, prospective clinical trial comparing the use of cyclosporin A with that of azathioprine and antilymphocytic globulin (ALG) in renal transplantation has been under way at the University of Minnesota Hospitals, and is aimed at determining cyclosporin A's effectiveness as well as whether steroid dosages can be lowered. Cyclosporin A is not without side effects, which include nephrotoxicity (thought to be easily reversible), hirsutism in some women and hepatotoxicity. Studies continue at other research institutes and if all goes well, cyclosporin A could be on the market by 1983. (*JAMA*, **July 10, 1981; 246:115-116)**

Levodopa for relief of Herpes Zoster pain

A significant decrease in intensity of pain was seen in a group of patients receiving levodopa for herpes zoster. Forty-seven outpatients were seen within five days of onset eruption and received ten days' administration of oral levodopa and benserazide or placebo in a double-blind controlled study. Both the total patient group and the high risk group (eg, those with either ophthalmic zoster or those older than 65 years) were analyzed. Both groups were comparable in terms of demographic and pathological criteria. Vomiting was the only side effect observed in both groups. A significant decrease in pain was seen in the group receiving levodopa from the third day and complete cessation of both pain and sleep disturbances was more frequent in the treated group. Two months later, postherpetic neuralgia was also less frequent in the group that received levodopa. (*JAMA*, **July 10, 1981; 246:132-134)**

Persistent Purulent Otitis Media

Of 429 children with acute otitis media who returned for follow-up evaluation, 49 were unresponsive to a 10- to 14-day course of ampicillin, amoxicillin, or erythromycin/ sulfisoxazole. Patients with persistent purulent otitis media (PPOM) were noted to have immobile, bulging, yellow or grey, abscessed tympanic membranes at the follow-up visit. A myringotomy was performed on 45 children. Cultures of middle-ear exudate yielded ampicillin-resistant Haemophilus influenzae in 14, ampicillin-susceptible pathogens (H. influenzae or Streptococcus pneumoniae) in 23 and no growth in eight. Patient compliance with the therapeutic regimen was not evaluated and probably accounted for most cases of PPOM, but not for all cases. PPOM can be expected to occur in one of every ten cases of acute otitis media treated with amoxicillin or ampicillin. One third of these apparent treatment failures is due to ampicillin-resistant bacteria. Fever is an uncommon sign in PPOM and pain is often absent as well. Reexamination of all children after treatment for acute otitis media is recommended by the authors. (*Clinical Pediatrics*, **July, 1981; 20:445-447)**

Tendinitis and Bursitis

Tendinitis is thought to arise from acute or chronic excessive use of a particular muscle group. Age-related changes at osseotendinous junctions may explain why tendinitis occurs most often after age 50. Bursitis often develops secondary to tendinitis. The most common cause of periarticular rheumatism is tendinitis and/or bursitis. However, the etiology remains obscure because histopathologic study is not feasible in the early stages of tendinitis. Local steroid injections are often palliative. Aspiration and injections must be done with careful sterile technique to avoid introducing infection into bursae and tendons. All synovial fluid obtained from such sites should undergo analysis and culture. Frequent injections increase the risk of tendon rupture. The majority of patients can anticipate significant improvement from conservative medical management. (*American Family Physician*, **June, 1981; 23:103-110)**

The chronic emergency department patient

The chronic emergency department visitor presents a common but largely unstudied problem. Using the criterion of one or more visits per month for a six-month period, a population of 16 frequent or chronic visitors was identified at Denver General Hospital. The chronic visitors were identified to be predominately single (94%), men (81%), with an average age of 48.5 years. Alcoholism was present in 87.5% and 56% were suffering from a chronic psychiatric condition. The majority were dependent on government support (75%) and lived alone (69%). Ambulance transport was used for 84% of the visits but in only 6% of the visits was hospital

admission required. The authors conclude that these patients became the responsibility of the emergency department by default because alcoholism or mental illness prevented their compliance with any therapeutic program, and because the ED is the only health care facility required to treat them. This group is at high risk for medical and traumatic illness and the physician must not let familiarity lead to careless evaluation.

After careful evaluation, and treatment if necessary, efforts should be made to refer the visitor to an agency such as an outpatient clinic, visiting nurse service, detoxification center or counseling service. The authors suggest the use of a "roster of chronic ED visitors" may improve both the quality and efficiency of care for this group. (*Annals of Emergency Medicine,* **June, 1981; 10(6):298-301)**

Ulcers in aged patients

In seven elderly patients, all over 60 with benign ulcers greater than 2 cm in diameter, numerous spores and mycelia of Candida were found in the inflammatory exudate and in the base of the ulcer. All patients were treated with Cimetidine and antacids. In five patients the ulcer failed to heal. Cimetidine was replaced with mycostatin and after four weeks of treatment the ulcers healed completely in four patients. It is assumed that in the elderly, due to the weakening of the host defense mechanisms, Candida may invade the base of the ulcer and disturb the normal process of healing. (*American Journal of Gastroenterology,* **March, 1981; 75(3):211-213)**

Bulimia

Bulimia, also known as compulsive eating, has recently been recognized as a disease. Theorized causes are primary neurologic dysfunction (epileptiform), disturbance in the appetite/satiety center of the hypothalamus, learned abnormal behavior or unsuppressed oral drive. Diagnosis rests primarily on the symptoms, which include compulsive or binge eating, bulimia nervosa, bulimarexia, the gorge-purge or binge-purge syndrome and the dietary chaos syndrome. Similar eating behaviors are sometimes associated with Kleine-Levin syndrome, Huntington's chorea, Parkinson's disease, oral contraceptive use, schizophrenia, the postictal state and anorexia nervosa: Bulimia occurs most frequently among young women and presents a diagnostic problem in several respects, note the authors: first, nutrition and eating behavior are issues often neglected by physicians; second, the secretive nature of this eating disorder makes it a difficult subject for the patient to discuss; third, the self-deprecating thoughts and depressed mood that are components of the disease can be misinterpreted; fourth, the requirement that these patients be made aware that their eating behavior is abnormal makes diagnosis of the disease impossible if they lack insight or deny symptoms; and fifth, because the only clinical sign is frequent weight fluctuation, the physician may base a diagnosis on symptoms alone without supportive physical findings and laboratory data. It is also unlikely that a patient will visit a physician to report physical problems directly related to this disease. No completely successful form of treatment currently is available, however current treatment measures include pharmacotherapy, aversion therapy and psychotherapy. (*American Family Physician,* **July, 1981; 24(1): 141-143)**

Child abuse

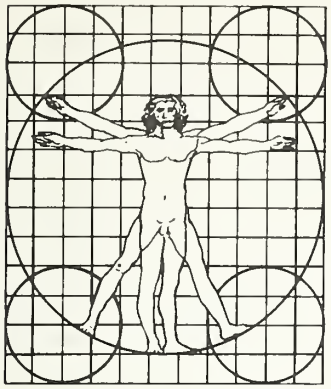
Several major explanatory models for child abuse have been proposed, however the author believes that child abuse should be examined from the viewpoints of the abusive individuals (the child-rearing histories of abusive parents) the family, the community and the cultural contacts. Premature infants appear particularly at risk because they may have the characteristics of other atypical infants, including developmental retardation, unresponsiveness and unattractiveness. Substantial evidence exists that crying often is the final stimulus triggering an abusive parental outburst. Abusers may differ from nonabusers because they have developed an abnormal response pattern through interaction with their offspring. The abused infant may be seen as adversive because of inborn characteristics or because of ineffective parenting skills. (*American Journal of Mental Deficiency,* **January, 1981; 341)**

Breast feeding and the pill

Breast feeding mothers can use oral contraceptives safely even though the quantity and ingredients of their breast milk may change. No unique effect of steroidal contraceptives on nursing mothers has been confirmed and no consistent long-term effects on children's growth or development have been described when the mother's oral contraceptive contained a combination of steroid agents, hormones, estrogen and progestin or progestin only. However, use of these contraceptive drugs in the immediate postpartum period may suppress lactation. Although breast feeding itself is a contraceptive action, mothers who want complete protection should not depend upon the contraceptive effects of breast feeding alone after about four to five weeks following delivery. Barrier contraceptives, such as the diaphragm, condom or intrauterine device would seem to have no effect on breast feeding. (*Pediatrics,* **July, 1981. Official policy statement of the American Academy of Pediatrics)**

Growth hormone for children

Some children with normal-varient short stature may be able to catch up if they are given extra doses of growth hormone. Researchers monitored growth rate and plasma immunoreactive somatomedin C concentrations in four subgroups of children eight to 11 years of age before, during and after six months of injection of growth hormone. In the two subgroups in which the average somatomedin C level was subnormal before treatment, the growth hormone restored levels to normal. In the other two subgroups whose average pretreatment somatomedin C was normal, growth hormone had little effect on somatomedin level or growth rate. The response provides a rapid method for identifying affected children who will benefit from long-term administration of human growth hormone. (*New England Journal of Medicine,* **July 16, 1981; 305(3):123-131)**



CLINICAL & SCIENTIFIC

EFFECT OF TRIPLE DYE CORD CARE ON BACTERIAL COLONIZATION IN NEWBORN INFANTS

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The effectiveness of triple dye was evaluated in relation to bacterial colonization. Two hundred eighty-five newborns received triple dye application and 195 did not receive any antibacterial cord care and acted as "controls." **Staphylococcus aureus** ***colonization of nose and umbilicus and*** **E. Coli** ***colonization of umbilicus were significantly greater in the control group.*** **Klebsiella** ***species were predominantly seen in the triple dye group. Triple dye cord care is an effective way to reduce staphylococcal colonization of newborns in a hospital nursery.***

NEWBORNS GET COLONIZED with different bacteria after delivery. Incidence and nature of neonatal infections are dependent upon the virulence and type of bacteria colonizing the infant. *Staphylococcus aureus* epidemics in nurseries increased in the mid-1940s.[1] Several investigators studied the carrier rate of *Staphylococcus aureus* in infants and concluded that a relationship existed between the rate of neonatal staphylococcal colonization and that of staphylococcal disease.[2,3] In the 1950s, bathing of newborns with 3% hexachlorophene was found to be an effective method for reducing the incidence of both staphylococcal colonization in the nursery and subsequent infections.[4,5] By the early 1970s, it was apparent that hexachlorophene had neurotoxic properties and the routine use of hexachlorophene for bathing of infants in nurseries was no longer recommended.[6] In 1972, The Center for Disease Control reported a sharp increase in staphylococcal diseases in nurseries which had discontinued hexachlorophene use.[7] Several regimens for umbilical cord care in newborns have been investigated with the goal of decreasing the bacterial colonization of the infants.[8-11] Investigators have commented on organisms other than *Staphylococcal aureus* in only a few of the studies dealing with the neonatal cord care and colonization by different bacteria.

This study was undertaken to evaluate the effect of triple dye on the neonatal colonization by gram-positive and gram-negative bacteria. Included in the study were 480 healthy normal newborn infants delivered vaginally at Saint Luke's Hospital and admitted to the regular nursery. Infants delivered by cesarean section, or to mothers who had premature rupture of membranes, or with other maternal and neonatal complications during labor or delivery, were excluded. A written informed consent was obtained from the mother of each newborn before enrollment in the study. All newborns were bathed with 10% liquid hand soap within six hours of delivery after their vital signs were stable. Newborns were divided into two groups:

1. *Control Group.* — Infants in this group did not receive any special antibacterial cord care after the bath.

2. *Triple Dye Group.* — After the bath each infant in this group received a single application of triple dye (ingredients: brilliant green 2.29 gm, proflavine hemisulfate 1.14 gm, gentian violet 2.29 gm, and water q.s. ad 1,000 ml) over the cord

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Submitted December 19, 1980.

TABLE 1

NASAL BACTERIAL COLONIZATION OF STUDY INFANTS

	Control (195)		Triple Dye (285)		
Organisms	No.	(%)	No.	(%)	p value
Staphylococcus epidermidis	102	(52%)	197	(69%)	N.S.
Staphylococcus aureus	94	(48%)	19	(6.6%)	<.005
Streptococcus Group B	27	(14%)	21	(7%)	N.S.
Streptococcus Non-group A, B, D, & G	58	(29%)	73	(25%)	N.S.

and surrounding one-inch area of the skin. The cord and skin were kept exposed until the area dried. Subsequently, both groups of infants received the routine care in the nursery which included contact with mother, breast or formula feeding, etc.

Bacterial cultures of the umbilicus and nares were obtained on all infants on the third day of life. One swab from the umbilicus and one from the nares were inoculated on two sheep blood agar plates; one McConkey's agar plate and one chocolate agar plate. All inoculated media were incubated at 37 C for 24 hours except one chocolate agar plate. The chocolate agar plate was incubated at 37 C in a 5% CO_2 incubator. Arbitrarily, colonies of different microorganisms were selected for bacterial identification by biochemical tests as well as for antimicrobial sensitivity studies.

Results

A total of 285 infants received a single application of triple dye on umbilical cord and surrounding skin within six hours of birth; 195 infants did not receive any antibacterial care and received the conventional nursing care (control group).

All newborns were colonized with at least one organism. Ninety-three percent of control infants and 48% of triple dye group infants were colonized with more than one organism. Tables 1 and 2 summarize the nasal and umbilical colonization rate of control and triple dye group.

Staphylococcus aureus colonization was significantly greater in the control group (both in nasal and umbilical cultures) as compared to triple dye group. *Staphylococcus aureus* was more often isolated from umbilical area than the nares of control infants. In infants receiving triple dye, colonization by *Staphylococcus aureus* on two sites was essentially identical (6% umbilical, 6.6% nasal).

Group B streptococci and non-Groups A, B, D, or G streptococci were more frequently isolated from the nasal passages of control group as compared with umbilical. Gram-negative bacteria were isolated essentially from the umbilical cultures and rarely seen in nasal passages. The umbilical colonization rate of *E. Coli* was 25% in control group as compared to 3% in triple dye group. These differences are statistically significant ($p<.005$).

Colonization by various species of *Proteus* was approximately 10% in both groups. Various species of *Klebsiella* were predominantly seen in triple dye group 27.7% (4.6% in control group) and this difference also was statistically significant.

Pseudomonas and other gram-negative organisms were occasionally isolated from infants in both groups but the differences were not significant. *Hemophilus* species were isolated from nasal passages of approximately 1.5% of study newborns. All isolates of *Staphylococcus aureus* were sensitive to methicillin. The penicillin resistance was approximately 88% in *Staphylococcus aureus* isolates. Antibiotic susceptibility patterns of *Staphylococcus aureus* isolated in control and triple dye groups were similar. Twelve out of 57 isolates of *E. Coli* were K_1 antigen positive.

Comments

These data clearly demonstrate the differences in bacterial colonization of two study groups. *Staphylococcus aureus* and *E. Coli* were colonizing approximately 64% and 25% of newborns who received conventional cord care without application of triple dye. Increased incidence of *Staphylococcus aureus* colonization also has been reported by other authors, and most recently by speck, et al.[11] The increased incidence of *E. Coli*

colonization has not been reported previously. Most of the previous studies commented only on the colonization by gram-positive organisms even though it has been well-known that gram-negative organisms play a major role in systemic infections in newborns and infants.[8-11] Twelve of 57 isolates of *E. Coli* were K_1 antigen-containing indicating potential for neuroinvasiveness and systemic infection. These K_1-containing *E. Coli* were isolated for both control and triple dye groups. Triple dye had no selective inhibition in colonization by K_1 containing *E. Coli*. However, no *E. Coli* disease was seen in any of the study infants.

Colonization by various species of *Klebsiella* was seen in approximately 27% of the newborns in the triple dye group. This has not been reported in previous studies. We did not see any disease caused by *Klebsiella* in any of the study infants who were colonized with this organism. Speck, et al, reported an increased incidence of Group B streptococcal (GBS) colonization in infants receiving triple dye.[11] Our study revealed no differences in GBS colonization in the two groups.

It is clear from our study that triple dye application reduces *Staphylococcus aureus* and *E. Coli* colonization, however, increase in *Klebsiella* colonization is noteworthy. Interaction of triple dye with various species of *Klebsiella* needs to be investigated to evaluate this problem. At present, the use of triple dye for neonatal cord care appears to be an effective way of controlling staphylococcal colonization. However, pediatricians should be aware of the certain gram-negative bacteria (ie, *Klebsiella*) in the newborns who are receiving triple dye cord care. So far there are no reports in the literature of an increase in the disease by gram-negative bacteria in newborns who have received triple dye cord care.

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TABLE 2

UMBILICAL BACTERIAL COLONIZATION OF STUDY INFANTS

	Control (195)		Triple Dye (285)		
Organisms	**No.**	**(%)**	**No.**	**(%)**	**p value**
Staphylococcus aureus	125	(64%)	18	(6%)	<.005
Streptococcus Group B	12	(6%)	16	(5.6%)	N.S.
Streptococcus Non-group A, B, D, & G	9	(4.6%)	15	(5.2%)	N.S.
Escherichia Coli	49	(25%)	8	(3%)	<.005
Proteus (Various species)	21	(11%)	29	(10%)	N.S.
Klebsiella (Various species)	9	(4.6%)	79	27.7%)	<.005

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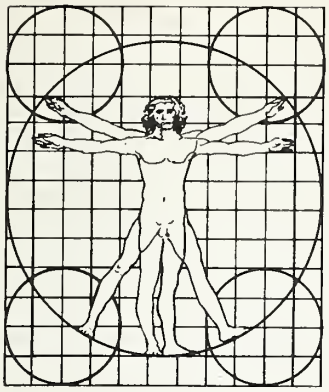


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CLINICAL & SCIENTIFIC

TOTAL HIP REPLACEMENT IN THE GERIATRIC PATIENT

John F. Williams, M.D.
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John J. Danyi, B.S.

The records of 298 consecutive patients undergoing 321 total hip replacement procedures were reviewed. The patient population was divided into two categories, those greater or less than 60 years of age. The groups were compared with regard to preoperative and postoperative incidence of cardiovascular, gastrointestinal, pulmonary, genitourinary, endocrine, neurologic, and hematologic abnormalities. Despite careful preoperative medical management, significant differences in the rate of postoperative complications in cardiovascular, gastrointestinal, and pulmonary systems persisted in patients over 60 years of age. However, the absence of mortality in this series, despite the incidence of medical complications, demonstrates the value of appropriate preparation for patients undergoing total joint replacement surgery.

ARTHRITIC MALADIES GIVE RISE to complications most frequently voiced by patients over 60 years of age.[1] Although these disorders are not fatal, they herald progressive deterioration in the general health of those afflicted. Patients in this category may become candidates for joint replacement operations because of arthritic involvement of major weight-bearing joints, and indeed, persons over 60 years of age comprise the majority of patients undergoing total hip replacement.

Because older patients are more likely than their younger counterparts to have other ailments also, a more complicated hospital course may be anticipated. To minimize postoperative morbidity and mortality, a thorough preoperative assessment cannot be overstated.

Scott and Associates[2] found that in a series of 13,000 major operations performed on patients over 70 years of age, the overall mortality rate could be reduced from 13.8% to 6.5% if patients with calculable operative complications were excluded preoperatively. In addition, a thorough preoperative medical evaluation should improve management of health problems that may affect the intraoperative or postoperative course of patients who do undergo surgery, and thus lessen postoperative morbidity.

Patients and Methods

The records of 298 consecutive patients undergoing 321 total hip replacement procedures from January 1978, to July 1979, were reviewed. Of the 298 patients, 56% had primary osteoarthritis, 20% had secondary osteoarthritis, 9% had rheumatoid arthritis, and 15% underwent revision procedures because of previously failed hip surgery.

Patients were admitted for preoperative evaluation three days before surgery was scheduled. Laboratory studies included complete blood count, coagulation studies, urinalysis, SMA-12, and arterial blood gases. Further studies included chest and pelvis roentgenograms, electrocardiograms, pulmonary function tests, and impedance plethysmography of the lower extremities.

The preoperative evaluation demonstrated that 89% of the patients anticipating hip replacement surgery had a significant history or laboratory abnormalities requiring further definition.

Patients were divided into two groups according to age. Patients younger than 60 years of age were classified Group A (38%), while Group B included patients 60 years of age or older (62%). Groups were compared with regard to preoperative and postoperative incidence of cardiovascular, gastrointestinal, pulmonary, genitourinary, endocrine, neurologic, or hematologic abnormalities. The presence of preoperative history or laboratory evidence of abnormalities was evaluated in patients who had postoperative complications.

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Submitted December 30, 1980.

Results

Preoperative Evaluation. — Overall, 56% of the patients displayed preoperative cardiovascular abnormalities, 37% of Group A and 67% of Group B (Fig. 1). Genitourinary abnormalities were displayed by 34% of the patients, 25% of Group A and 39% of Group B. Abnormalities of the gastrointestinal system were found in 24% of the patients, 16% of Group A and 29% of Group B. Preoperative abnormalities in the endocrine system were encountered in 19% of the patients, 11% of Group A and 25% of Group B. Pulmonary abnormalities were evident in 37% of the patients, 33% of Group A and 39% of Group B. The overall incidence of preoperative hematologic abnormalities was 4%, 5% of Group A and 4% of Group B.

In the cardiovascular, gastrointestinal, genitourinary, and endocrine systems, there was a statistically different incidence of abnormalities between Groups A and B ($p<.01$). There was no statistically significant difference between Groups A and B in the pulmonary, neurologic, or hematologic systems.

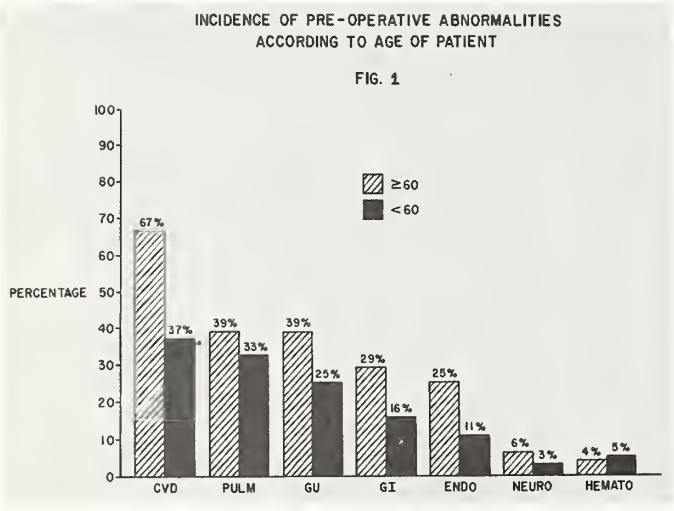
Postoperative Complications. — Cardiovascular complications occurred in 22% of all patients, 14% of Group A and 26% of Group B, representing an 87% greater incidence in Group B than in Group A (Fig. 2). Postoperative cardiovascular complications were experienced by 28% of those patients with a history of cardiovascular abnormalities, while only 14% of those patients without a prior history had similar complications (Fig. 3). Thus, those patients with a preoperative history of cardiovascular abnormality had a 93% greater chance of having cardiovascular complications, a difference which is statistically significant ($p<.01$).

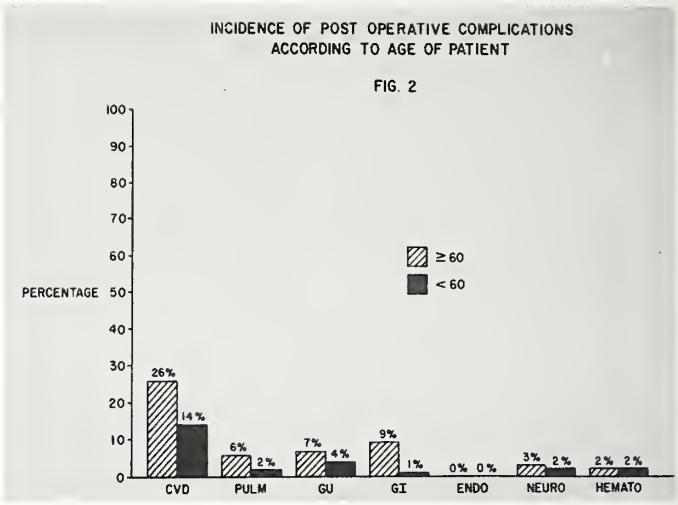
There was a 4% total incidence of pulmonary complications postoperatively, 2% of Group A and 6% of Group B. This greater incidence in Group B was statistically significant ($p<.01$).

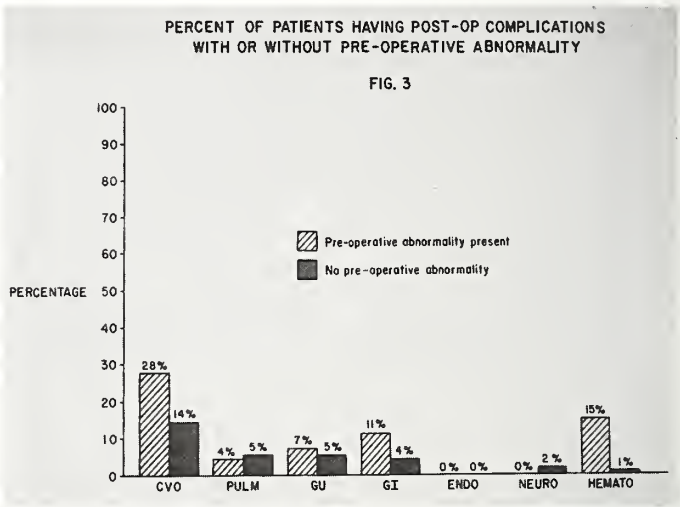
Gastrointestinal complications occurred in 6% of all patients, 1% of Group A and 9% of Group B. This difference was significant statistically ($p<.01$). Among patients with a preoperative history of gastrointestinal abnormalities, 11% had postoperative gastrointestinal complications, while only 4% of those without such a history had similar complications.

The genitourinary complication rate overall was 6%, 4% of Group A and 7% of Group B. There were no endocrine postoperative complications. Neurologic postoperative complications occurred in 2% of the patients. There was no statistically significant difference in the incidence of postoperative complications of the endocrine, genitourinary, neurologic, or hematologic systems between Group A and Group B.

There were no patient fatalities in this series.







Discussion

Although the chronologic age is not always a decisive consideration in determining a patient's candidacy for surgery, the fact remains that older persons exhibit more health problems than the total population.[3] Because of this, they are at greater risk to have operative and postoperative complications without special management of existing abnormalities. Even with careful preoperative medical management, significant differences in the rates of postoperative complications in cardiovascular, gastrointestinal, and pulmonary systems persist in patients over 60 years of age. However, the absence of mortality in this series, despite the incidence of medical complications, demonstrates the value of appropriate medical evaluation in preparation for total joint replacement surgery.

For his part, the patient is as concerned with his capacity to lead an independent life as he is to lead a longer life, and many patients over 60 years of age are willing to accept an additional calculated risk of joint replacement surgery in order to increase their activity and improve their quality of life. It remains the duty of the surgeon, as well as other members of the health

care team, to minimize the risk of surgery in the geriatric patient population. Effective management can result in the patient enjoying his final years in comfort and independence.

Summary

From January 1978, to July 1979, 298 consecutive patients undergoing 321 total hip replacement procedures were reviewed. Patient population was divided according to age into two categories (over and under 60 years of age). A comparison was made between postoperative complications and preoperative abnormalities.

In those instances in which postoperative complications occurred, determination was made as to whether or not a preoperative abnormality in that given area existed prior to surgery. Those patients over 60 years of age were more likely to have preoperative abnormalities in the cardiovascular, pulmonary, and gastrointestinal systems than those under 60 years of age. Similarly, those same patients exhibited a greater instance of postoperative complications in the cardiovascular and gastrointestinal systems than their counterparts. However, in the pulmonary, genitourinary, hematologic, neurologic, and endocrine systems, those with preoperative abnormalities were not significantly more likely to develop postoperative complications in the respective systems than those without a preoperative abnormality. The absence of mortality in this series indicates the value of appropriate medical evaluation for those geriatric patients undergoing total hip replacement.

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Solution to Puberty Crossword on page 678

ACROSS: **1.** Precocious, **5.** Estradiol, **8.** Ova, **9.** Optic, **11.** Ovary, **14.** Smell, **16.** Testosterone, **20.** PCO, **21.** Cafe Au Lait, **23.** Nine, **25.** Tanner, **28.** HCG, **30.** Alpha, **31.** Menarche, **32.** Fun, **33.** Sleep, **35.** Pituitary, **37.** Puberty, **38.** Craniopharyngioma, **39.** XO.

DOWN: **1.** Progesterone, **2.** One, **3.** Idiopathic, **4.** Sperm, **6.** Short, **7.** Leydig, **10.** Sella, **12.** Five, **13.** Slow, **15.** Testes, **17.** TBG, **18.** Estrogen, **19.** Gynecomastia, **22.** Low, **24.** Three, **26.** Kallmann, **27.** CAT, **29.** Ectopic, **34.** Hypo, **36.** Two.

Colleagues in the News (continued)

The Village Council of Kalida presented a plaque to **CHARLES R. KIDD, M.D.** in recognition of his 25 years of service to the community. Dr. Kidd is a general practitioner and is on the staff at St. Rita's Medical Center.

The Hiram College's 1981 Alumni Achievement Award was presented to **WALTER B. WEBB, M.D.** Dr. Webb has practiced in Ravenna since 1946.

ROBERT J. WHITE, M.D., Cleveland, is the only foreign physician requested to consult with Italian doctors in Rome on the condition of Rev. Pedro Arrupe, head of the Society of Jesus. Rev. Arrupe recently suffered a stroke. Dr. White is director of neurosurgery at Cleveland Metropolitan General Hospital.

THOMAS F. MEANEY, M.D., Cleveland, was elected to the Board of Chancellors of the American College of Radiology. Dr. Meaney is chairman of the Cleveland Clinic Foundation's division of radiology, and a trustee and guest examiner of the American Board of Radiology.

PAUL R. ZEIT, M.D., Burton, was elected vice president of the American Cancer Society, Ohio Division. He has been medical advisor to the ACS, Geauga County Unit, since 1975. Dr. Zeit is chief of gynecologic oncology at Hillcrest Hospital, and president of the Geauga County Medical Society.



Employment Opportunities

ANESTHESIOLOGIST: Cincinnati group seeks a board-certified or board-eligible anesthesiologist. Excellent employee benefit plans, including profit sharing and pension plan, health insurance, disability insurance and life insurance. All professional dues and insurance paid. Call collect (513) 772-1034 or send Curriculum Vitae to: A.S.W.O., Inc., 11490 Springfield Pike, Cincinnati, Ohio 45246.

ASSISTANT MEDICAL DIRECTOR - "THE LAKELAND INSTITUTE": Responsible for medical/administrative functions of three-phase alcoholism treatment program (detox - 15 inpatient beds; rehab - 28 day, 50 beds; 1 year - aftercare). Fully accredited by JCAH for alcoholism treatment in new $3 million facility; located on campus of 343-bed progressive community hospital; 35 miles west of Cleveland. Interest and/or experience in alcoholism treatment required. Contact Jeffrey Leimgruber, (216) 282-9121, Ext. 3287. Lorain Community Hospital, Lorain, Ohio 44053.

EMERGENCY DEPARTMENT PHYSICIAN - CLEVELAND, OHIO: New emergency group desires career-minded emergency physicians. Opportunity is unlimited. Superior starting salary; vocational and educational leave; malpractice and hospital insurances paid; other fringe benefits available. Since we are a new group without prior commitments, full participation in the group's corporate structure is anticipated for the correct physician within one year. Call for interview: Mitchell W. Leventhal, M.D., President, Medical Emergency Services, Inc., phone: 216/888-4411 or 831-4095.

EMERGENCY PHYSICIAN

Immediate opening for full-time physician for Ohio JCAH-approved community hospital. Attractive salary and benefit package including malpractice insurance and pension plan. Send CV or call collect: Dolores Mittelstadt, Emergency Consultants, Inc., 4050 Executive Park Drive, Suite 208, Cincinnati, Ohio 45241, (513) 563-7054.

EMERGENCY PHYSICIANS - Full time, career-oriented, Northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including professional liability insurance. Full department status. Ohio license required. Write J. J. Cahill, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094 or call (216) 946-4546.

FAMILY PRACTICE PHYSICIANS - Residency Trained - Several excellent practice opportunities available in satellite locations near prestigious Ohio community. Private practice or hospital-based arrangements available with full provisions for new office facilities. Guaranteed first-year income provided with other incentives. Please forward C.V. in confidence to Box No. 927, c/o Ohio State Medical Journal, 600 S. High St., Columbus, Ohio 43215.

GROUP PRACTICE IN NORTHERN OHIO has opening for general surgeon - board eligible - willing to do small amount of general practice. Small community near large metropolitan areas. Reply to Box No. 915, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

MEDICAL SERVICES DIRECTOR COLUMBUS, OHIO DEPARTMENT OF HEALTH

Assistant health commissioner position for a $12 million health department in the nation's 19th largest city. We are seeking an individual to plan and supervise sexually transmitted disease, alcoholism, pediatric dentistry, and laboratory programs. This person will function as the medical spokesperson for the department and serve as medical consultant to all other programs, including a comprehensive ambulatory care system, community home health services, immunization clinics and WIC program. This position will also provide an opportunity for clinical and/or faculty affiliation with the Ohio State University School of Preventive Medicine. Applicants must be licensed or eligible to be licensed to practice medicine in Ohio and must have one year's experience in a public health agency or possess a Master's Degree in Public Health or health-related field. Salary established by Board of Health. Excellent fringe benefit package. For further information contact:

Frances L. Baby
Assistant Health Commissioner
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Columbus Department of Health
181 S. Washington Blvd.
Columbus, Ohio 43215
Phone: 614/222-7732

GENERAL SURGEON SEEKING PRACTICE opportunities in solo or group in Ohio. Reply to Box No. 928, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

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- a professional association -

Emergency Positions - available with emergency physician group in PA, NY, NJ, VA, WVA, MD, KY and throughout New England, the Southeast and the Midwest, including all suburban, rural and metropolitan areas. Fee-for-service with minimum guarantee provided. Malpractice paid. Practice credits toward board certification. Physician department directors also desired. Please send resume to: NEEMA Emergency Medical, Suite 400, 399 Market Street, Philadelphia, PA 19106 or phone 215-925-3511 in PA, or 800-523-0776 outside PA.

PHYSICIAN - GENERAL MEDICINE: St. Barnabas, Inc., situated in a lovely suburban location midway between Butler and Pittsburgh, Pennsylvania, is seeking a general practitioner (geriatric care included) to join its staff at its outpatient medical center. Excellent opportunity for a family practice. St. Barnabas, Inc. consists of an outpatient medical center, a 107-bed nursing home, and a newly established retirement village. Forward curriculum vitae, in confidence, to: D. Connelly, Personnel Director, St. Barnabas, Inc., 5827 Meridan Road, Gibsonia, Pa 15044. EOE M/F

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Contact **VICTOR ALBAINY, M.D.,** Medical Staff Office, Parma Community General Hospital, 7007 Powers Blvd., Parma, Ohio 44129 or call 216-888-1800, extension 260.

RADIOLOGIST

Radiologist needed for one-physician department in small progressive JCAH-accredited community hospital. We are located in the midwest great lakes area. Salary $100,000 plus. Please send current detailed resume to Box No. 925, c/o Ohio State Medical Journal, 600 S. High St., Columbus, Ohio 43215.

WANTED: Obstetrician and gynecologists to join two others in an active Central Ohio practice. First year salary guaranteed, excellent fringe benefits. Reply to Box No. 924, c/o Ohio State Medical Journal, 600 S. High St., Columbus, Ohio 43215.

EMERGENCY MEDICINE: Assistant directorship and emergency physician positions available in a teaching institution in Northwestern Ohio. EMS and ACLS involvement preferred. Remuneration 90-100K including fringes. Respond with CV to Edwin Pont, M.D., C.S. No. 10008, Hospital Support Center, Toledo, Ohio 43699.

EMERGENCY PHYSICIANS - dynamic group of career-oriented emergency department professionals has limited openings for Ohio licensed emergency physicians in a teaching institution. EMS and ACLS involvement perferred. Attractive compensation and fringes. Respond with CV to Susan Masterson, Emergency Medical Services Associates, 8200 W. Sunrise Blvd., Building C, Plantation, FL 33322. 800/327-0413

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GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

FOR SALE: Established modern industrial medical center, completely equipped, in thriving industrial area in Northern Hamilton County, near Cincinnati, Ohio. Close to hospitals. In almost new medical building (with income from other tenants) also available for purchase (optional). Excellent tax shelter. Attractive terms. Doctor retiring. Reply to Box No. 926, c/o Ohio State Medical Journal, 600 S. High St., Columbus, Ohio 43215.

FOR LEASE, COLUMBUS, OHIO: Up to 9,000 sq. ft. **NORTH**, across from Riverside Hospital. Spacious suites, will finish to tenant specifications. Landlord pays all utilities. Excellent freeway access and parking. **SOUTH,** near Mercy Hospital, two suites, 845 sq. ft. and 1,087 sq. ft. Cathedral ceilings, ample parking, pharmacy, close to downtown and freeway. Landlord pays utilities. Contact The Denmead Company, (614) 224-1492.

Vacation Property

FOR RENT: St. Thomas, U.S.V.I. - Anchorage Beach Villas - Elegantly decorated luxury condominium, two bedrooms, two baths, lighted tennis courts, fresh water swimming pool, secluded white sand beach - **INTRODUCTORY OFFER** 1-4 persons, $600/week, from January 4th to May 1st. Make your reservations now for best selection of dates available. **CALL** (513) 399-8259 or (513) 399-6557, evenings.

Classified rates to change

As of January 1, 1982, the rates for classified advertising will be as follows:

Normal Classified: $5 per line.

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Box Number Reply: $7 per three or less insertions.

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For help contact:
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Another Service of Your OSMA

Medical Crossword

By R. M. Benson, M.D.

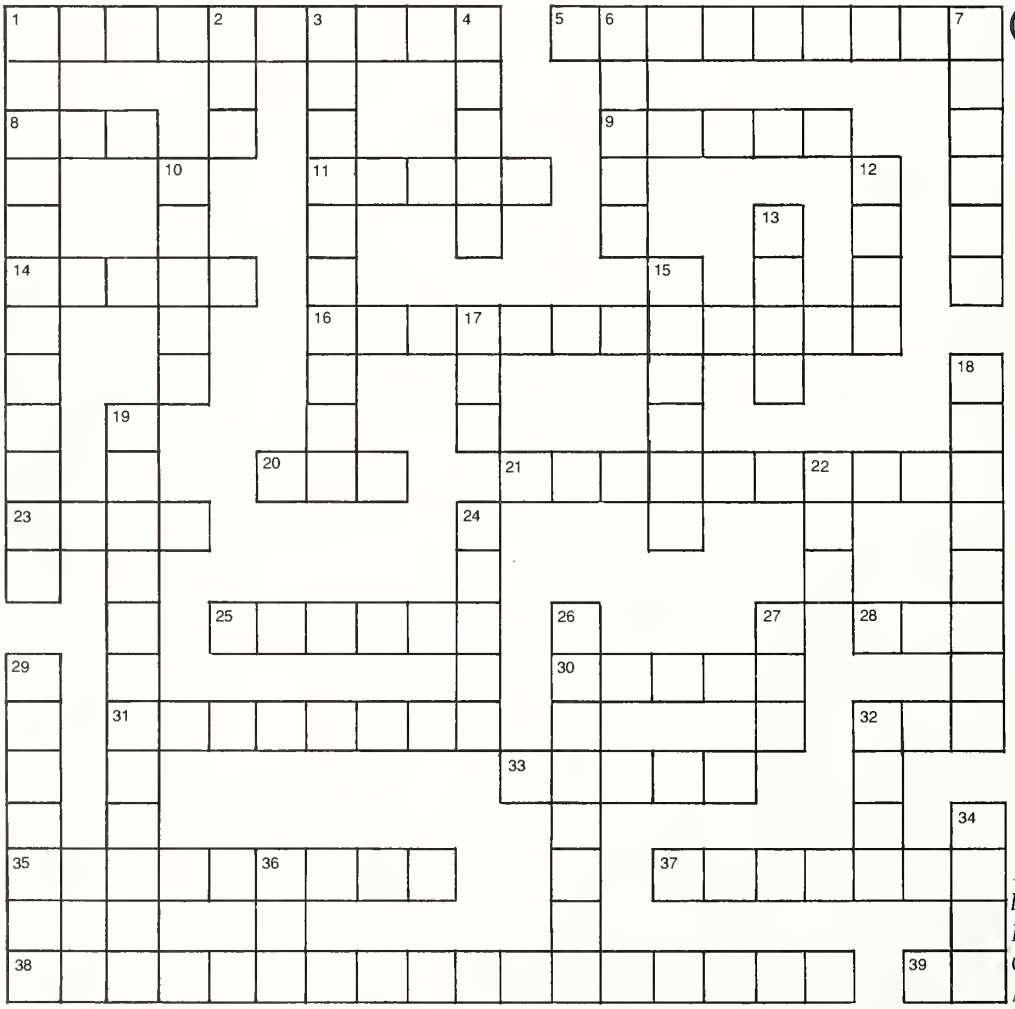
Puberty

ACROSS:

1. Male puberty before nine years, female puberty before eight, **5.** Potent form of eighteen down, **8.** Female reproductive cells, **9.** Hypoplasia syndrome with delayed puberty and absent septum pellucidum, **11.** Gonad formed with XX Karyotype, **14.** Decreased sense in twenty-six down, **16.** Major male hormone, **20.** (Abbr) Syndrome of obesity, decreased menses, and hirsutism, **21.** Spots with polyostotic fibrous dysplasia and precocious puberty, **23.** Puberty before this age is early in males, **25.** Five stage scoring system for pubertal development, **28.** (Abbr) Common hormone culprit in twenty-nine down, **30.** Common peptide chain to LH, FSH and HCG, **31.** Pubertal event averaging twelve and three quarter years in American females, **32.** Biased reaction to making this puzzle, **33.** First pubertal bursts of LH occur during this activity, **35.** Glandular source of LH & FSH, **37.** Maturation of gonadotropin gonadal axis, **38.** Cystic tumor of Rothkes pouch often causing hypogonadism, **39.** Common Karyotype in very short females with streaked gonads.

DOWN:

1. Female hormone rising after ovulation, **2.** Prepubertal Tanner Stage, **3.** Most common etiology of female precocious puberty, **4.** Male reproductive cells, **6.** Stature in patients with slow biological timeclock and delayed puberty, **7.** Cell source of sixteen across, **10.**_____ turcica, **12.** Adult maturity Tanner type, **13.** Relaxation phase of DTR with hypothyroidism and precocious puberty, **15.** Gonads with H-Y antigen present, **17.** (Abbr) Thyroid carrier protein elevated by eighteen down, **18.** Major ovarian hormone causing breast and endometrial growth, **19.** Common breast condition affecting adolescent males, **22.** Gonadotropin levels in thirty-seven across, **24.** Tanner Stage with a small definite mound of breast tissue below adult size, **26.** Syndrome of hypo-osmia and low gonadotropins, **27.** Head scan obtained on males with one across, **29.** Endogenous gonadotropin source from outside the pituitary, **32.** Tanner Stage with adult breast mounds and pouting areola, **34.** Thyroid state with precocious puberty and galactorrhea, **36.** Tanner Stage with earliest appearance of pubic hair.



(solution is on page 673)

Dr. Benson is the Director of Pediatric Endocrinology at Children's Hospital Medical Center, Akron.

THE Ohio STATE Medical Journal
(ISSN 0030-1124)

Features

Anxiety and the Doctor-Patient Relationship 689

Richard Sutton, M.D.

Every time a patient enters your office there is always a certain amount of anxiety present — whether it's coming from his end or yours. Is it something that should be treated . . . or is anxiety something that should be left alone?

In Search of Medicine's Morals 693

Karen S. Edwards

The story of a Cleveland neurosurgeon whose quest for medicine's principles have taken him all the way to the Vatican.

Van Gogh's Illness 699

James G. Ravin, M.D.

What was the reason behind Van Gogh's driving, often frantic lifestyle, reflected so vividly in his paintings? A now-renowned art aficionado and member of the OSMA's new Art and Culture Committee takes a look.

Competition or Regulation? 705

Karen S. Edwards

First it was regulation. Now it's competition. How will medicine cope with this latest government strategy? OSMA leaders recently met to learn more of this recent development in health care.

The Psychological Aspects of Parkinsonism..... 711

George W. Paulson, M.D.

An examination of the personality state of the patient with Parkinson's disease.



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Clinical & Scientific

Vitamin and Trace Element Requirements in Parenteral Nutrition: An Update..... 725

Robert L. Ruberg, M.D.
Jay Mirtallo, M.S., R.Ph.

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Our Cover

Houses at Auvers, painted by Vincent Van Gogh. Printed here with permission of the Toledo Museum of Art.

OSMA Councilors

Listed below are the OSMA Councilors and the districts they represent. If you have any questions or concerns regarding OSMA, please address them to your Councilor.

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Motorola, Inc. 702
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Physicians Insurance Company of Ohio 696, 697, 698
PICO Agencies 714
PICO Life 704
Roche Laboratories ..... Cover 2, 679, 680, Cover 3, Cover 4
Telecourse Systems 690
Turner and Shepard, Inc. 721
U.S. Air Force 723
Windsor Hospital 716

COLLEAGUES IN THE NEWS

ROBERT A. ANDERSON, M.D., Wooster, will chair the professional division for the 1981 United Way campaign for 1982 member agency budget needs.

DONALD D. ANTHONY, M.D., Cleveland, was appointed chairman of the Pilot Research Committee for the American Cancer Society, Ohio Division. Dr. Anthony is an associate professor of pharmacology and an assistant professor of medicine at Case Western Reserve University School of Medicine.

RAY W. GIFFORD, M.D., Cleveland, was named vice chairman of the Council on Scientific Affairs of the American Medical Association.

HELEN GLUECK, M.D., Cincinnati, was honored at the Hadassah, Cincinnati Chapter, Myrtle Wreath Awards Luncheon.

JOSEPH P. MYERS, M.D., Youngstown, was named director of infectious disease service in the Department of Medicine at Youngstown Hospital Association. Dr. Myers is an assistant professor of medicine at Northeastern Ohio Universities College of Medicine.



Carl A. Lincke, M.D., left, and OSMA Executive Director Hart Page

OSMA Past President Receives 50-Year Award

CARL A. LINCKE, M.D., who served as President of the Ohio State Medical Association (OSMA) during 1949-1950 was presented with the Association's 50-Year Award during a recent meeting of the Carroll County Medical Society. The award is given to those member-physicians who have completed 50 years of medical practice. Dr. Lincke graduated from Ohio State University in 1931 and remains active in his general practice in Carrollton, Ohio. He is the oldest surviving past president of the OSMA.

ASIKIN MENTARI, M.D., Cleveland, was named director of physical medicine and rehabilitation at St. Alexis Hospital. Dr. Mentari is a specialist in physical medicine.

A. BURTON PAYNE, M.D., Ironton, was elected vice-president of the Ohio Valley Health Services Foundation, Inc. of Athens. Dr. Payne also will continue as a member of the executive committee.

MOVING

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by Karen S. Edwards

Growth hormone promotes rise in children's stature

Some children with normal-varient short stature may be able to catch up if they are given extra doses of growth hormone. Researchers monitored growth rate and plasma immunoreactive somatomedin C concentrations in four subgroups of children eight to 11 years of age before, during and after six months of injection of growth hormone. In the two subgroups in which the average somatomedine C level was subnormal before treatment, the growth hormone restored levels to normal. In the other two subgroups whose average pretreatment somatomedin C was normal, growth hormone had little effect on somatomedin level or growth rate. The response provides a rapid method for identifying affected children who will benefit from long-term administration of human growth hormone.

Ohio Cancer Information Service — providing a link to the facts —

Although the Ohio Cancer Information Service (OCIS) is nearly three years old, there are still many Ohioans, including health-care professionals, who are unaware of the services this unique resource center provides.

The OCIS, sponsored by the National Cancer Institute through Ohio State University's Comprehensive Cancer Center, offers a statewide, toll-free telephone number which has already been used by more than 8,000 Ohioans seeking further information about cancer.

"Whatever the questions, we answer them as accurately as possible, with up-to-date fact sheets and other materials that have been approved by physicians, the National Cancer Institute, and other cancer-affiliated organizations," says Nancy Kesselring Brant, director of the OCIS.

"We neither diagnose cancer, nor recommend treatment," Brant emphasizes. The specially trained volunteers will, however, provide general information on the causes of cancer, its symptoms, and how cancer is diagnosed and treated. They also have information on nursing care, financial aid programs and rehabilitation assistance.

For the health professional, the OCIS offers several publications which are specifically designed for them. Bibliographies on screening programs, treatment and patient education are available to those who are interested.

For further information about the programs and services provided by OCIS, call 1-800-282-6522, the Service's toll-free number.

New positions for two OSMA Staffers

The Council of the Ohio State Medical Association (OSMA) recently approved the appointment of Mr. Herb Gillen to the new position of Deputy Executive Director to the OSMA. Mr. Gillen was formerly the Director of the Department of Government Relations.



Herb Gillen

Mr. David Pennington, formerly the Director of Health Planning, has been promoted to the position of Director of the Department of Government Relations.



David Pennington

Meetings

American Society for Laser Medicine and Surgery, Annual Meeting: January 25-27; Marriott's Hilton Head Resort, Hilton Head Island, South Carolina. Business meeting and scientific exhibits will be featured. For further information, write: 425 Pine Ridge Blvd., Suite 203, Wausau, Wis. 54401.

Pediatric Dermatology Seminar IX: February 25-28; Carillon Beach Hotel, Miami Beach, Florida. Guest speakers include: Richard Dobson, M.D. and Yehudi Feldman, M.D. For further information, contact: Guinter Kahn, M.D., 16800 NW 2nd Avenue, Miami, Fla. 33169.

American Heart executive to retire

Walter S. Page, Jr., the executive vice president of the American Heart Association, Ohio Affiliate, Inc., has announced his retirement effective January 15, 1982. Page has been in this position for 29 years and with the American Heart Association for a total of 35 years.

Notice to All OSMA Members

Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA,* will expire on December 31, 1981. Here's how to renew:

Mail your dues now to the SECRETARY-TREASURER OF YOUR COUNTY MEDICAL SOCIETY or to the OSMA. OSMA direct bills for all dues levels if requested to do so by the county society.

OSMA dues are $195. AMA membership dues are $285. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee-American Medical Political Action Committee (OMPAC-AMPAC) dues are $50. OMPAC-AMPAC membership is recommended.

Member-in-Training — OSMA dues are $20. Membership entitles physician to all privileges including the right to vote and hold office.

Student Membership — a category of membership for full-time students enrolled in medical schools approved by the AMA. OSMA dues are $15.

Nonresident — If you are planning to move from Ohio, you may wish to continue your Ohio affiliation with this category of membership. Annual OSMA dues are $40.

Send one check to cover local, state, national, and OMPAC-AMPAC dues. Your local Secretary-Treasurer will forward your state and national dues to the OSMA Columbus Office for distribution to AMA and OMPAC.

As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal,* the *OSMAgram* and *Synergy,* without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA* and the *American Medical News.*

The member who becomes eligible for exemption from dues, because of retirement or disability, should notify the Secretary-Treasurer of his/her County Medical Society. After exemption has been established, it will be renewed annually unless the status changes.

For further information on medical society membership contact:
Mrs. Katherine Wisse, OSMA Comptroller, telephone: 614/228-6971.

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The 1982
Ohio State Medical Journal
Photographic Exhibit



The Ohio State Medical Journal is sponsoring its fifth annual photographic exhibit and competition. The 1982 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1982 Annual Meeting, Dayton, where the entries will be displayed.

Photographs may be entered in two divisions: Black and White, and Color. Each division has two categories: General and Scientific.

Entries must be in print form (8″ x 10″ or 11″ x 14″) in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs placed under glass will not be accepted. All entries submitted must be previously unpublished, and right to publish the photograph must be given to the Journal at the time the photograph is entered in the exhibit.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a $10.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.

ENTRY FORM

Name _____

If Nonmember, Spouse's Name _____

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City _____ *State* _____

County _____ *Zip* _____

Telephone _____

Information about photograph:
(provide as much as possible)

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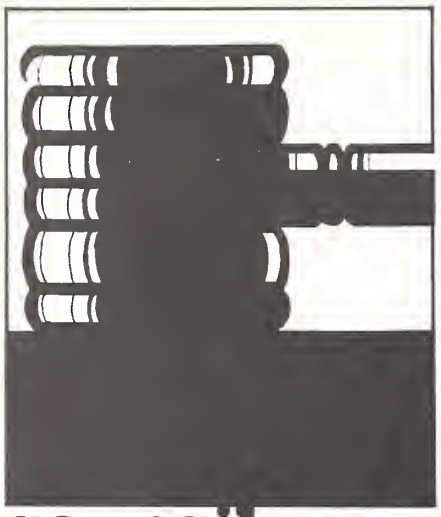
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Mail or hand carry the photograph, entry form and $10 entry fee (make checks payable to The Ohio State Medical Journal) to: The Ohio State Medical Journal Photographic Exhibit, 600 S. High Street, Columbus, Ohio 43215. All entries must be received no later than March 26, 1982.

I give the *Journal* publication rights to this photograph. I certify that this photograph has not been published previously and that I will not submit it for publication elsewhere pending the judging of the photographic exhibit. Also, I certify that any person(s) pictured have given me authorization to allow publication of his/her photograph. I also understand that if my photograph is selected for a Journal cover, it may be cropped to meet printing specifications.

_____
Signature



council proceedings

PROCEEDINGS OF THE COUNCIL

October 31, 1981

The Council met October 31, 1981, at the Columbus Marriott Inn-North, Columbus, Ohio.

The following Councilors were present: Stewart B. Dunsker, M.D., Cincinnati; C. Douglass Ford, M.D., Toledo; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; Benjamin H. Reed, M.D., Wauseon; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; Joseph L. Kloss, M.D., Akron.

Guests present were: John H. Budd, M.D., Cleveland; Oscar W. Clarke, M.D., Gallipolis; A. Robert Davies, M.D., Troy; Shirley C. Davies, Troy; John J. Gaughan, M.D., Cleveland; Edward E. Grable, M.D., Canton; Charles L. Hudson, M.D., Bratenahl; W. J. Lewis, M.D., Dayton; Robert N. Smith, M.D., Toledo;

Staff members present were: Hart F. Page, CAE; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.; Robert E. Holcomb; Gail E. Dodson; Richard A. Ayish; David C. Torrens; Carol W. Mullinax; David W. Pennington; Eric L. Burkland; Michael L. Bateson; Louis N. Saslaw; Cathy Costello.

The Council *approved* the submission of a resolution to the December meeting of the AMA House of Delegates having to do with tightening the rules for granting delegate representation in the AMA House of Delegates to additional medical specialty interest groups.

The Council *approved* support of an IRA investment program which is being developed by Physicians Life Insurance Company of Ohio.

The Council *approved* OSMA support of the candidacy of Dr. Albers for the AMA Council on Medical Education and the candidacy of Dr. Ray W. Gifford, Cleveland, for re-election to the AMA Council on Scientific Affairs.

The Council *approved* the submission of a resolution to the December meeting of the AMA House of Delegates requesting the JCAH consider revising JCAH-AMH 82.

ATTEST: Hart F. Page, CAE
Executive Director



Anxiety

and the doctor-patient relationship

by Richard Sutton, M.D.

A reasonable amount of anxiety is a normal, healthy, appropriate force that, in moderation, increases alertness and effort, motivates learning and growth, and expedites decision making and action. Anxiety results from maintained uncertainty and is particularly associated with unfinished business. Anxiety is a basic physiologic and affective response to the perception of immediate or anticipated danger. Only excessive anxiety, or the absence of anxiety in situations in which it would be appropriate, can be considered "pathologic."

A patient's anxiety is clinically significant if it is exaggerated, inappropriate, or grossly disproportionate to the external or internal circumstances that trigger or sustain it. It is clinically significant if it provokes functional complaints, exacerbates organic symptoms, or depletes the patient's capacity to handle the pressures and problems of daily living.

THE PATIENT'S ANXIETY

When a patient comes to your office he is experiencing anxiety. He wonders what his particular symptom means and what will be the consequences. "Is my arm broken? Do I need an operation? Am I having a heart attack? Do I have a brain tumor? Or cancer?" More covertly he may be worried that he may be unable to function sexually or that he will die. He will both consciously and unconsciously construct explanations for his ailment in an effort to relate his anxiety. An example is physician-patient with classical symptoms of myocardial infarction— "It's probably indigestion!" Another example is a policeman I saw in consultation after doing his morning push-ups in ICU to the utter dismay of the staff. The thought of the "dependent" was so anxiety provoking to him that he was unable to allow others to care for him even though his medical situation clearly warranted it.

When physicians become anxious in a doctor-patient relationship, the reasons may be complex, but recognizing this anxiety and trying to understand it may provide clues to the patient's difficulty.

The question that arises is clear. How does one deal with patient's anxiety? An initial history, physical examination, and other examinations as indicated, can be given with verbal reassurance and a clear understandable explanation of what is wrong, the treatment, and the probable outcome. If a gallbladder must be removed, it is extremely important to tell the patient why and what to expect not only immediately post-op but what the effects of living without a gallbladder will be. It is necessary to tell the patient the location and function of the organ. One would be amazed at the fantasies conjured up at the suggestion of removing an organ. "Will I now have diabetes? Will I be able to have sex again? Will my spouse still love me now that I am not 'whole'?" These questions usually are not asked for various reasons — "I'm too embarrassed. The doctor will think I am stupid." And many times not anticipated or answered —



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"Everybody knows about appendicitis — it's routine." Routine for the doctor may be overwhelming and devastating for the patient.

THE DOCTOR'S ANXIETY

What if these initial efforts at alleviating the patient's anxiety fail? Too often the busy practitioner will prescribe a tranquilizer in an effort to treat the patient's anxiety. Sometimes he will prescribe a medicine for the patient to treat his own anxiety. After all, if his examination, diagnosis and treatment plan failed, maybe he feels he is at fault (neurotically) for the patient's illness. Maybe, he worries, he is not a good doctor.

There is a curious progression of thinking in regard to minor tranquilizers sold to the medical profession and the public as a whole. Recognizing anxiety as a complement of physical illness as well as an unwelcome and often disavowed part of daily living, the drug companies have come to the "rescue" with a variety of minor tranquilizers. This sounds like a pretty good idea. In fact, these medicines can be quite useful as a short-term adjunct to many medical and psychotherapeutic treatment plans. However, there are side effects that are not listed on the package inserts. One side effect is the attribution of "cure" in the subsequent psychological dependence upon the medicine and physician. Sometimes this seems to work and both the patient and the physician are less anxious (temporarily). Another side effect is masking the difficulty or never dealing with the source of pathologic anxiety. More often than not, social, psychological, or medical symptoms will continually emerge until the "problem" is solved. Examples of this are numerous and include the patient with multiple elective surgeries occurring in anniversary fashion following the unresolved loss of a loved one.

If the original cause of anxiety was too low a blood level of diazepam, then adding diazepam would be a quite rational approach!

When physicians become anxious in a doctor-patient relationship the reasons may be complex, but recognizing this anxiety and its derivatives, and trying to understand it, may provide clues to the patient's difficulty. I have a colleague who gets a burning pain in his stomach when interviewing certain types of drug addicts. He uses his symptoms diagnostically and refers the patients, who sometimes denied the illness, but invariably are afflicted, to appropriate treatment facilities.

To treat (anxiety) would be to deprive the patient of developing positive coping mechanisms with which to face daily living.

Often anxiety is stimulated in physicians when they are unable to make a diagnosis or when they feel uncomfortable treating a certain person or illness. At that point they ask for consultation, which, if successful, will relieve both doctor's and patient's anxiety. An example of this is the round-robin referral. Internist to neurologist: "Even though there were no localizing signs, something didn't feel right about this 'hysterical conversion.'" Neurologist to psychiatrist: "No focal signs; brain scan, EEG, and x-rays are negative." Psychiatrist to neurosurgeon: "Although the psychodynamics fit like a glove, mental status exam reveals subtle memory impairment." The diagnosis by CAT scan was made, a parasagittal meningioma was surgically removed, and the patient recovered without sequellae.

THE DOCTOR-PATIENT ALLIANCE

Much has been written in the psychiatric and medical literature about the doctor-patient relationship. It is the sine qua non for any treatment plan to be successful. All diagnostic and therapeutic endeavors fall within this very special relationship. The best diagnostician is rendered useless if the patient will not take his medicine as directed. Anxiety within this relationship should be used whenever possible to further the patient's growth and autonomy.

Normal anxiety is a reasonable and appropriate force that stimulates adaptation and provides opportunities for furthering understanding. To treat it would be to deprive the patient of the growth-conducive benefits of developing positive coping mechanisms with which to face and solve problems of daily living. It is an asset that should be conserved. OSMA

Richard G. Sutton, M.D., is a member of the Ohio State Medical Association, is certified by the American Board of Psychiatry and Neurology, and practices psychiatry in Middletown, Ohio.

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Then, as now, Dr. White had come to the Vatican to probe the ethical side of medicine with one of the world's foremost religious authorities. He had come. . .

In Search of Medicine's Morals

by Karen S. Edwards

As Cleveland neurosurgeon, Robert J. White, M.D., climbed the stairs, a flicker of color outside the window caught his eye. He looked and saw a short length of clothesline stretched taut between two invisible poles, its collection of clothing fluttering like banners in the mild October breeze. Anywhere else, the scene would have seemed commonplace, hardly worth a second glance. But this was the Vatican, and somehow the scene touched him, making the sumptuous apartments he was about to enter seem a little less formidable.

He was escorted to a waiting area just outside the private apartments of Pope John Paul II. A cardinal approached him and politely asked if he would mind waiting for a few minutes, as the Pope was running a little behind schedule.

Dr. White chuckles at the recollection.

"How was I supposed to answer that? 'I'm sorry, but I have another errand to run, so I'll come back later'"?

"Of course not," he answered, and he waited — just as he had on six previous occasions when the late Pope Paul VI had been wearing the papal robes of office. Then, as now, Dr. White had come to the Vatican to probe the ethical side of medicine with one of the world's foremost religious authorities. He had come in search of medicine's morals.

As a pioneer in the area of brain surgery (during the early 1970s, Dr. White performed the first brain transplant in animals to observe how the brain and body relate and interact), he had been acutely aware for some time of the quantum leaps medical science was taking. But, as a religious man and a member of the Catholic Church, he was becoming increasingly uncomfortable with the ethical paradoxes these advancements were creating. Were medicine's "modern miracles" really as good as they appeared, or were they, in fact, dangerous explosives, threatening to uproot the very basis of civilization?

Are medicine's "modern miracles" really as good as they appear, or are they, in fact, dangerous explosives?

"In the fall of 1979, I participated in a conference in Italy, known as the Nova Spes," Dr. White says. "Twenty-four world-renowned scientists, physicists and Nobel laureates met to discuss the impact of technology on human existence."

Although nothing concrete came from the conference, it did give Dr. White the kernel of an idea.

"I had discussed biomedical ethics with Pope Paul on several previous occasions, but after participating in the conference, I could see the importance of research in these nebulous areas. I thought it might be a good idea for the Vatican to establish a commission, an ongoing one, in which scientists and theologians from all over the world and various religious persuasions meet to discuss medico-ethical matters. Their findings then could be used as a resource by the Pope and the Vatican officials when developing a position on a medical-moral issue."

Dr. White approached Pope Paul with the suggestion, and while the

Pontiff was receptive, asking numerous questions, he seemed hesitant to take any action.

So Dr. White did not push the idea for a commission any further.

Then, last year, events took a strange course, bringing the Cleveland physician once more to the Vatican.

"I happened to be in Italy on a lecture tour, when Cardinal Cararoli, the Vatican's Secretary of State, asked me to see a friend of his as a patient."

He listened intently, and when, at last, he did speak, it was to encourage Dr. White to put all of his thoughts on paper.

Dr. White decided to ask the Cardinal for an audience with the Pope, and within a short time, he received an invitation from the Vatican.

So it was, on that fine October day, that Dr. White sat patiently waiting for his audience with the Pope.

The wait, according to Dr. White, was worthwhile.

"I had a 45-minute private audience with the Pope. Usually such audiences include 30 or 40 people sitting around the walls of the room, but this visit it was just the two of us. We didn't even use an interpreter. We spoke in English."

Although the Pope did not ask as many questions as his predecessor, he listened intently to the ideas brought forth by the physician from Cleveland, and when at last he did speak, it was to encourage Dr. White to put all of his thoughts on paper.

"He said he would read my proposals himself and make his decision," says Dr. White. "As he pointed out, 'These are very deep problems that take a lot of thought.'"

Since then, Dr. White has been engrossed in his project.



Robert J. White, M.D.

"I am making it clear, first of all, that the Commission serve the Pope and Vatican authorities in an advisory capacity only, that it have no power."

But a myriad of questions crop up. Is it appropriate to handle the make-up of the Commission by country and multidenominationally? What type of subjects should be discussed — biological warfare? Cloning? Transplants? Brain death?

"It's important for the Catholic Church to consider information that is pertinent to the practicing physician," says Dr. White, and he ticks off those areas which he feels are most important.

"As I see it, the major problems in our present-day practice include abortion and the whole area of test-tube babies, and artificial insemination. Then, there's the area that includes research and exploration of the human nervous system — chemical modification of the brain and psycho surgery."

He pauses and leans forward.

"The brain is a repository — the totality of human civilization. We have to understand that. Religion spins from the human mind. It's incumbent of human religion to understand the human brain, and how it relates to theology."

He's concerned too with genetic engineering; transplantation; the definition of death and euthanasia.

"How should physicians conduct

themselves with the dying?" he asks rhetorically.

The Commission that Dr. White envisions would take a hard look at this and other such difficult questions.

"As I see it, members of the Commission would take a subject — say biotechnology — and research it, collating their material. Then they would meet together as a group and probe the scientific nature of the subject — how it was being used in the medical community, for example. Members would think about it, prepare a document, then discuss the pros and cons in a meeting with theologians.

"The theologians would be able to provide information based on past theologic beliefs," he continues. "Those held by Aristotle and Thomas Aquinas, for example. It would provide a 'meeting of the minds,' the scientific and the religious, which has been missing these last few years, but which is needed now more than ever."

"Human morality and human ethics are the very basics of the human experience," he concludes, and although Dr. White is the first to admit that the Church usually is "not the most applauding of medical advancements," he adds that the Church has become more lenient of late, and is "really very reasonable."

Such a Commission would provide a "meeting of the minds," the scientific and the religious.

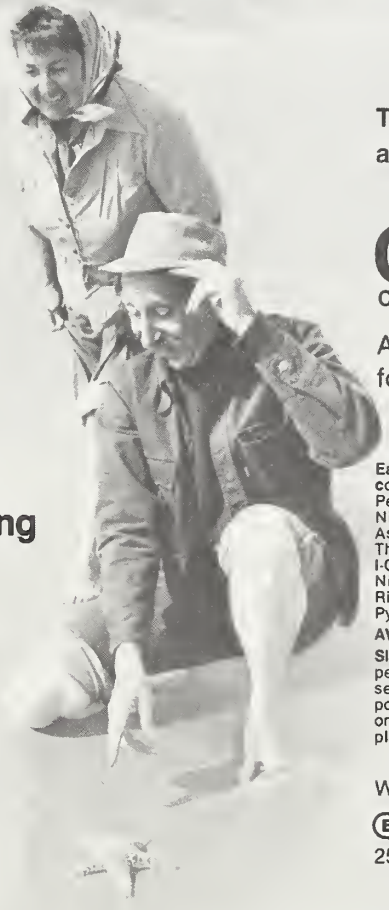
"The physician, however, has to maintain his position of respect in society. He has to be able to give sympathy, to be able to develop a rapport with his patients.

"The physicians of today are probably a little less concerned with morality of medicine than we were years ago," Dr. White philosophizes.

"That's not to their discredit. Physicians are the products of their environment, and society as a whole, has become less moral than it was years ago. There's been a social and religious stigma for years, and we don't make the moral demands of our young people as we once did.

"But the new physician has a whole new armament of medical techniques to draw from, and the question of ethics, of morality, is eventually going to come. Even if only because the economics of medical care are causing us to ask, 'Can everybody receive quality medical care, or just those who can afford it?'"

Dr. White's proposed Commission may or may not have the answers. But, like Hippocrates, his efforts are proof once again that the medical profession recognizes its duty — not just to the outer person, but to that touch of living divinity that rests in all of us. OSMA



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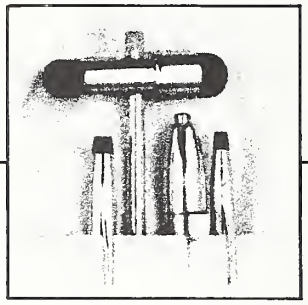
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Houses at Auvers, Vincent Van Gogh (printed with permission of the Toledo Museum of Art).

Van Gogh's Illness

By James G. Ravin, M.D.

Vincent Van Gogh's art is greatly admired today. He is known as a romantic artist who painted in a unique powerful manner. However, during his lifetime (1853-1890), he was virtually ignored. His personality did not attract friends. He was impulsive, hot tempered, brooding, moody, and unsociable. Only his brother felt he was a significant artist, and not until the last year of his short life did he finally sell a painting.

Van Gogh's problems began at birth. One year to the day before his birth, his parents had another child, also named Vincent, who died shortly after he was born. The baby was buried in the village church. As a child, Van Gogh saw the tombstone with his own name on it every Sunday as he attended services.

Van Gogh became a minister like his father. After conflicts with church authorities, he was relieved of his duties. Perhaps in a cynically defiant mood, he moved in with a pregnant alcoholic prostitute. He saw himself as an unloved failure. He worked for a while for an art dealer, but was once again fired. He did not take up painting until late in his twenties, but then painted prolifically for the last ten years of his life.

As early as age twenty-five he spoke of suicide. He lived briefly with an artist who moved out when Van Gogh

suggested a suicide pact. Later he drank turpentine and ate some of his oil paints in suicide gestures. (However, we should not be too harsh on Van Gogh for taking turpentine. Like many other compounds, it was used in the last century to treat mania.) His diet was frequently meager, for days consisting of bread and coffee. He developed scurvy and lost some teeth. In 1888, Paul Gauguin accepted his offer to live with him. They soon quarreled, and Van Gogh threw a glass of absinthe at Gauguin. The next day he threatened Gauguin with a razor and Gauguin moved out. Later that day, Van Gogh cut part of his left earlobe off and gave it to a prostitute. He was in and out of psychiatric hospitals for the next four months. He was agitated, confused, suspicious, and suffered from auditory and visual hallucinations and insomnia. He spent most of the last year of his life as a voluntary inmate of an asylum. His physician diagnosed epilepsy, chronic sunstroke, and turpentine intoxication.

The end came when Vincent borrowed a pistol and went out for a walk in the country. A farmer saw him sitting in a tree and heard him mutter, "It is impossible." He shot himself in the chest, but was able to return to the asylum where he died two days later at the age of thirty-seven.

The end came when Vincent borrowed a pistol and went for a walk in the country. A farmer heard him mutter, "It is impossible." —

Bipolar disorder, mixed, (manic-depressive illness) is the most likely diagnosis of Van Gogh's illness.[2,3] This diagnosis was not known during his lifetime. The term epilepsy was used then to cover a far greater range of disease than now. Van Gogh's problems also may have been aggravated by chronic consumption of absinthe.[4,8] Absinthe contains the chemical, thujone, a convulsant. Manufacture of absinthe is now illegal in most countries because it induces behavioral problems.

There is a theory that Van Gogh suffered from acute glaucoma.[5] The evidence for this theory is as follows: (1) Emotional outbursts may trigger attacks of acute glaucoma, and Van Gogh certainly had many emotional upsets. (2) Patients with acute glaucoma usually have swelling of the cornea which causes them to see colored haloes about light sources. Colored haloes may be found around lamps and stars in several of his paintings. (3) Patients with acute glaucoma usually have the pupil of the affected eye dilated during the attack. Several of his self-portraits show the mirror image of his left eye dilated. We know that Van Gogh tried to copy what he painted accurately. For example, photographs of the scene at Auvers, France, taken sixty years after

Dawn of a new creation

Throughout the centuries, medicine and art have influenced one another. It is evident, for example, in the drawings of Leonardo da Vinci, where artistic expression and scientific description seem to exist side by side. For da Vinci, in particular, art was a tool of research into many areas of medicine, particularly anatomy.

Therefore, it's hardly surprising that, in a membership as large as the Ohio State Medical Association (OSMA), there would be a group of physicians who are as interested in art as da Vinci was, at one time, in medicine. A year ago, the OSMA's House of Delegates approved the formation of a new standing committee — the Art and Culture Committee — to serve the needs of that specific group of physicians.

Chaired by long-time art aficionado, Harry H. Fox, M.D., Cincinnati, the committee is comprised of members who themselves are all active participants in the arts. Their primary goal, as outlined by Dr. Fox, is to increase and share their interest with other OSMA members.

"This committee provides an opportunity for those of us who share a love of the arts to pursue art and cultural activities together," he says.

The committee focuses on projects which it feels will help increase the enjoyment of art. They intend to offer weekend trips to coincide with special art exhibits and cultural activities being conducted in various cities. The committee also hopes to convince physicians who have gathered extraordinary art collections to share their masterpieces through private showings. Art exhibits, in which talented OSMA members can participate also are planned.

Music appreciation is another area in which the committee hopes to be influential. For example, the group is currently considering the idea of using music composed or recorded by OSMA members as background music at various meetings and social functions.

In addition, the committee hopes to involve the Auxiliary in the committee's activities and to establish a History of Medicine library for the membership's browsing pleasure.

Those may sound like ambitious plans, but Dr. Fox is well qualified in getting such projects off the ground. His efforts have already proven successful in the Cincinnati area, where he has been a driving force in organizing and promoting countless art exhibits, introducing "opera evenings," travel/art lectures and ballet nights for Cincinnati physicians. Why did he choose to launch his project at the state level? "Because I feel there is a definite need for such programs throughout the state."

His other committee members share an equal enthusiasm for cultural activities. Jack L. Harris, M.D., Middletown; D. James Hickson, M.D., Mt. Gilead; Victor C. Laughlin, M.D., Cleveland; James G. Ravin, M.D., Toledo; and Ludolph van der Hoeven,

(continued on page 722)



The Wheat Field, Vincent Van Gogh (printed with permission of the Toledo Museum of Art).

The fact that many of his late works (such as "The Wheat Field") have a large amount of yellow in them have led some to believe Van Gogh suffered from digitalis toxicity. But, of course, wheat fields *are* yellow . . .

he painted "Houses at Auvers," are recognizable as the subject. The glaucoma theory is interesting. However, there is no good evidence from records made during Van Gogh's lifetime to substantiate it.

Recently, another diagnosis that has been offered is that Van Gogh suffered from digitalis toxicity.[6] The evidence given in support of this includes the fact that many of his late works have a large amount of yellow in them. The toxic effects of digitalis include color vision abnormalities. Most often yellow or green vision occurs, but red, brown or blue vision is possible. Van Gogh's painting, "The Wheat Field," was cited as showing a yellow cast — although, of course, wheat fields are yellow.

Also cited as proof of his digitalis toxicity is the fact that Van Gogh twice painted his last physician, Dr. Gachet, with a foxglove plant on a table in front of him. Digitalis is a product of the foxglove plant. It was used to treat mania during the last century:

> The digitalis has been much celebrated, and no doubt succeeds in some instances. . . Like all other medicines of the same class, it must be given when the accession of fit is characterized by great frequency of the pulse, extreme mobility, and palpitation of the heart. . .
>
> In France, the digitalis has been particularly praised.[7]

Dr. Gachet was a homeopathic physician. According to homeopathic theory, minute doses of drugs suffice to treat most illnesses. Minute doses of digitalis are not likely to cause yellow vision.

Van Gogh created a new form of romantic art that has great appeal today. Bright colors and writhing shapes form the basis of his unique style. The designs are simple yet accurate representations of the scenes he painted. Van Gogh's personal style of painting reflects his vibrant energy. This warm emotional art is most enjoyable.

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(continued)

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Credit and credibility

Usually, our authors' credit lines are short and succinct. But when a recent Bulletin of the Academy of Medicine of Toledo and Lucas County included an editorial on James G. Ravin, M.D., proclaiming "A Star is Born," we decided to take a closer look.

We discovered that Dr. Ravin's credentials for authoring this piece are more than impressive. They're awesome.

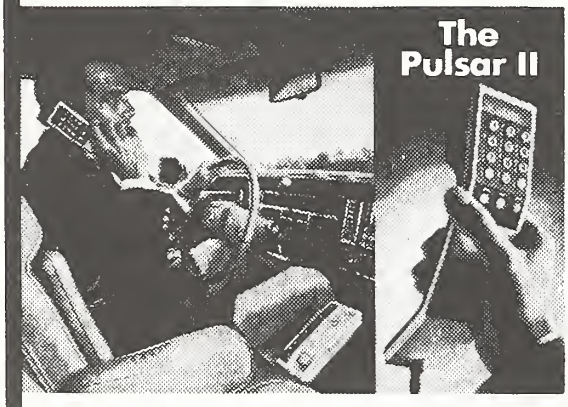
As a premedical student, he wavered back and forth between his wish to become a doctor, and his consuming passion for art. As it was, his college career featured almost as many studies in art history as anatomy, and he even spent time studying illustration with a well-known local artist.

By the time Dr. Ravin received his medical degree, he was as well versed in his avocation as his vocation, so it was hardly surprising when the American Academy of Ophthalmology asked him to present a speech on "Ophthalmology and the Fine Arts," at their Annual Meeting in Chicago.

The speech marked something of a turning point for Dr. Ravin. Suddenly, he was being interviewed by the *Chicago Tribune* for his theories about the Impressionist painters being near-sighted. The *Chicago Sun Times* did a story, and the AP jumped on the bandwagon. Soon Dr. Ravin was receiving calls from Washington, D.C., California, New York City, Alaska, Michigan, Florida, even India and New Zealand. He did countless radio interviews, both taped and live; he was quoted by Jane Pauley on "Today"; and furnished background information to David Hartman for a spot on "Good Morning America."

Currently, Dr. Ravin is serving on the Ohio State Medical Association's Art and Culture Committee, and continues to practice ophthalmology in Toledo.

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Competition or Regulation?

OSMA leaders take a look at what the 1980s have in store for medicine

By Karen S. Edwards

There's a new buzz word these days in health care. The word is competition," and already it's being bandied about on Capitol Hill with the same ease that "regulation" once was discussed during the days of the Carter Administration.

But those days of Califano, Kennedy and tightly-regulated politics are rapidly drawing to a close. The New Administration is now turning to the private sector for help in controlling costs, and that means both marketing and competition will be playing ever-increasing roles in the provision of health care.

In order to better understand the implications behind this latest government strategy, the Ohio State Medical Association (OSMA), under the direction of its president, Stewart B. Dunsker, M.D., recently held a leadership conference which explored the area of competition and marketing and its possible effect on the medical profession.

Speakers in medicine, law, politics and economics were brought to the Marriott Hotel in Columbus from as far away as Washington, D.C., to take a "prospective look" at this new trend and to advise OSMA leaders of possible steps they could be taking now to assure more quality care, at less cost to the professional.

"By 1990, 9.9% of the GNP will go to health care. But there's going to come a time society decides that's too much."

"One of the problems that we're facing," says Thomas A. Helmrath, M.D., the Vice Chancellor of Health Affairs, the Ohio Board of Regents, "is that, each year, more and more of the Gross National Product (GNP) is going toward the health care sector. In fact, by 1990, 9.9% of the GNP is predicted to go toward health care. But," he warns, "there's going to come a time when society decides that's too much going into one realm. Then what?" he asks.

"At the same time, physician manpower is increasing. Seven medical schools here in Ohio are producing larger numbers of physicians each year. For example, between 1970 and 1980, the number of physicians in Ohio increased 38% and the number of medical school graduates increased 128%."

In describing the situation further, he alluded to an analogy that's been made before.

"We have to observe what is basically a 'Table of Manners at a Health Care Feast.' The table is filled with people, but there's not enough food to go around. Pieces have to be cut smaller and smaller."

So, competition will naturally — eventually — come into play.

"I think, for awhile, things will continue status quo. Medical schools will continue to operate at full capacity, and there will be a reduction in government control. But there will be increased interest in the subspecialties, and opportunities for nonphysicians will become scarce," he predicts. "There will also be more self-insured, and a move away from the Blues, because other forms of insurance will become available."

He stresses that physicians, too, are going to have to help cut costs, and suggests that the medical profession turn back to thinking their cases through.

"Technology has seduced us . . . but physicians are going to have to start using their internal computers."

"Technology has seduced us," he says. "Now, residents get a gold star when they think of all possible things that might be wrong, and order laboratory tests to substantiate them. Thinking the treatment through is not being taught in medical schools anymore, but physicians are going to

have to start using their internal computers if they want to affect a cost savings."

But with competition come difficult questions that will have to be answered. David C. Main, Jr., Esq., a partner in a Washington, D.C. law firm and appointed to the staff of Reagan's Committee on Competition, raises a few.

"Does competition overemphasize the insurer's responsibility to contain costs? Can it provide enough care for everyone? Are consumers educated enough to make choices? The enthusiasm for competition rose as an alternative to Califano and Kennedy and government regulation," Main says. "But Washington remains dubious about it. There are still a number of differences that need to be resolved."

"If the public thinks physicians are only interested in for-profit health care, the profession will run some serious risks."

For example, not everyone is happy with the recommendations submitted by the Committee on Competition so far — recommendations such as tax capping and Medicare vouchers.

"But there is no one political force pushing for competition since regulation is no longer in the picture," explains Main.

Today's physician, Main believes, is going to have to weigh the dangers of competition against the dangers of regulation, then develop a strategy for his own practice if he wants to survive.

"If the public thinks that physicians are only interested in for-profit health care, the medical profession is going to run some serious risks. There must be an emphasis on quality of care, with reasonable flexibility, of course."

How do insurers fit into this picture? They are often blamed as much as physicians for the high cost of health care. How will third parties compete?

"Third parties are already experimenting with various means of cutting costs," says Marilyn Field, Ph.D., Director of Health Policy Development, Blue Cross/Blue Shield, but she's unsure as to whether vouchers are the answer.

"I don't think vouchers can buy as much access to care as the present system can," she says. "Because of inflation, vouchers will buy less each time. Their individual administration is an expensive way to do business, and they can be confusing to the consumer."

The theory, she says, is that by limiting tax, providing multiple choice and by giving rebates, lower costs can be achieved.

"But serious questions are raised regarding quality of care," she says, as is the threat of adverse selection. "The sick will pay more, the well will pay less. It's a bear of a problem, not easily tamed."

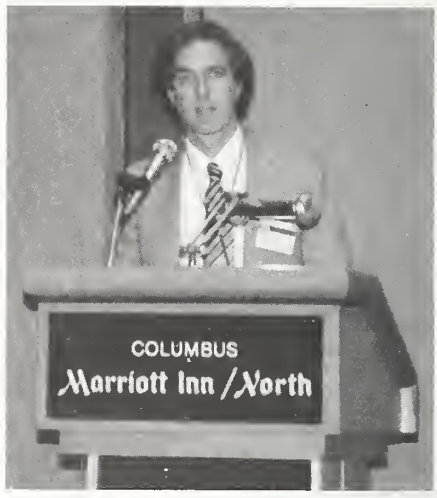
Perhaps the answer, she suggests, lies in a combination of competition and regulation, where there is equity **and** access.

Jack Meyer, Ph.D., a resident Fellow in Economics at the American Enterprise Institute, agrees that we need to make use of more innovative programs in solving the rising health care problem.

"There is a growing gap between needs and the capability of the federal government to meet those needs," he says. "The teeter-totter has flipped. Defense spending is now at the top, social services have sunk to the bottom, and suddenly, everyone is scrambling to protect their own benefits."

"Regulatory ways are ineffective. The doctors become the fall guys when government tries to deflect attention away from itself with regulations. And shifting the burden down to lower levels of government isn't going to do it either."

"We need to be more careful who we give our federal dollars to; we need to think of better ways to get the job done more efficiently: we need to restructure some government programs — building in cost-saving measures — and return others to their original intent. And we have to rely more on the private sector."



Jack Meyer, Ph.D., Economist



Marilyn Field, Ph.D., Blue Cross/Blue Shield

As the rest of the speakers have already noted, there are and will be problems with competition — but Meyer also urges physicians to weigh them against those problems present in the current system.

"The fears of plunging into a more competitive, deregulatory world are unjustified," he says. OSMA

The Psychological Aspects of Parkinsonism

By George W. Paulson, M.D.

ABSTRACT

The psychological aspects of parkinsonism include a complex mixture of drug effects and depression as well as the influence of cortical atrophy and normal aging phenomena. Levodopa can lead to confusion, nightmares, or even psychosis. An obsessive compulsive personality has been tentatively linked with the tendency to develop extrapyramidal disease, but there is more clinical relevance in the depression so often seen in patients with parkinsonism. Even when there is no affective disorder there may be apparent overlap in clinical symptoms between depression and parkinsonism.

PSYCHOLOGICAL ASPECTS OF PARKINSONISM

James Parkinson specifically stated that intellectual decline was not part of paralysis agitans, but psychological problems and dementia both are seen as complicating features of the disorder. There are many aspects of parkinsonism that mimic depression in the effect of the disease on patients and on their families. Patients with parkinsonism may also be seen by psychiatrists because of the effects of cortical atrophy or because of the noxious effects of antiparkinsonian medications.[1,2] The usual psychological stresses linked to advancing age[3] are intensified in patients with this chronic disease. Some of the psychological features of parkinsonism are summarized in this review, utilizing clinical experience with over 400 patients with parkinsonism and employing a selective review of the literature.

PREEXISTING PERSONALITY STATE

The personal qualities of patients are a partial determinant in parkinsonism and have been discussed in the literature since the time of encephalitis lethargica. It was once thought that those who manifested extrapyramidal disease were more obsessive-compulsive than was true for the population at large.[4] Since many neurologic diseases seem linked with such a personality,[5] and since both the ability and the desire to go to a physician may also be linked with meticulousness, the apparent linkage between an obsessive nature and parkinsonism may have no validity. Rigidity of stance need not be linked to inflexibility of manner. Undoubtedly, encephalitis lethargica once did lead to parkinsonism, and some patients developed temporary or permanent mental changes secondary to encephalitis lethargica.

In most cases of parkinsonism there is not a particular preexisting mental peculiarity and also usually no history of encephalitis; but the previous personality undoubtedly influences adjustment to the disease. The underlying personality influences the initial and continued reaction of the patients which ranges from a stout-hearted persistence in daily activities to persistent feelings of worthlessness and frank withdrawal from the community at the first sign of tremor. Furthermore, although there is no firm data to substantiate it, it seems likely that some of the effects of medication depend on the preexisting personality. For example, dreaming and nighttime

"The personal qualities of patients are a partial determinant in parkinsonism and have been discussed in the literature since the time of encephalitis lethargica."

hallucinations due to levodopa may be accentuated in a patient who normally has a vigorous and vivid dream life.

Nevertheless, it should be emphasized that most patients with parkinsonism are remarkably normal prior to the onset of illness. The most usual statement is, "I never had to see a doctor before this happened." There is even some evidence that there is a negative correlation between parkinsonism and smoking or alcohol as has been suggested by at least two observers.[6,7] The reason for an inverse correlation between smoking and parkinsonism is unclear; perhaps smokers have a higher normal level of dopamine. Thus, the correlation may not be between nonsmoking and parkinsonism but between high levels of dopamine and ease of addiction to smoking. The stability of the patients with parkinsonism and of their marriages is remarkable when contrasted with a disease such as multiple sclerosis.

CHANGES WITH THE DISEASE

Parkinsonism does, of course, eventually lead to major social and psychological changes in the patient, no matter how stable the preexisting personality might have been and even with optimal response to chronic disease or to a disease "of the mind." Selby and others have emphasized that cortical atrophy occurs concomitantly with parkinsonism,[8] and most patients do complain of difficulty with recent memory. In the later stages, thinking as well as movements become slowed. Subtle decline in memory may prompt the patient to relinquish control of finances, job, or conversational interaction.

The average patient has a spouse who finally becomes responsible for total care, and this aging spouse may be unable to cope either physically or financially with the ravages of chronic illness in a loved one. It is perhaps for this reason that individuals and groups supported by Parkinson foundations, or clubs for patients and families, have been so successful in recruiting new members.

Levodopa and anticholinergic medications both have major effects on the nervous system as is now well known to internists, psychiatrists and neurologists. Confusion, delusion or hallucinations in particular are seen with these drugs.

PSYCHOLOGICAL FACTORS IN INITIAL COMPLAINTS

The psychological state of the patient also may be reflected in the character of initial complaints, even before parkinsonism is formally identified. For example, patients who cherish or need writing skills may note problems with these as the chief complaint; whereas, for others loss of force in the speaking voice is the most bitterly lamented defect. Loss of normal posture and facies is embarrassing for all, and before diagnosis is certain, the postural deficit is commonly attributed to the presence of small strokes or to dementia. One of the most common initial complaints of the patient is bursitis or arthritis and is most likely to be mentioned in patients with a somatic orientation.

"The psychological state of the patient also may be reflected in the character of initial complaints, even before parkinsonism is formally identified."

Depression, either valid or misidentified, is a common initial diagnosis for the patient with parkinsonism. Depression and its relationship with parkinsonism is an interesting area, and is one complaint for which therapy is available. Some of the diagnostic criteria for depression overlap with parkinsonism. Insomnia, hypersomnia, and other distortions of sleeping patterns are almost universal in patients with moderately advanced parkinsonism. Physical retardation, of the same type seen in depression, is usual in parkinsonism and may alternate with periods of agitation or restlessness. In the late stages of the disease weight loss is almost universal, and anorexia and difficulty swallowing are troublesome late complaints for patients with parkinsonism. Apparent lack of interest in pleasure is probably secondary not only to the physical retardation and facial appearance but also is due to the great deal of effort required to perform any normal action. Nevertheless, the family may complain of the patient's apathy and misinterpret it as a sign of depression. Other classical features of depression can be seen in parkinsonism and Parkinson himself mentioned fatigue and lack of energy.[9] Families find it hard to motivate patients to participate in previously cherished activities, but the depressive sense of worthlessness or guilt is probably uncommon in parkinsonism, except for concern about the burden placed upon a spouse. Decreased ability to remember and concentrate is universal, and the patient may manifest great delay in responding to questions. In addition to other aspects of parkinsonism that would be confused with depression, occasional patients have repetitive thoughts of death, but suicide is extremely uncommon in this age group and in this group of patients.

In summary, which psychological aspects may be misinterpreted as representing depression? There are certainly a few obvious ones, including the mask-like facies, lack of mobility or a tendency to sit without stirring, increased withdrawal from community activities, change in sleeping and eating habits, impotence or loss of sexual interest, and a remarkable variability at different times of the day in the ability to perform routine activities.

What is the relationship between depression and parkinsonism? There are several obvious links, including depression as the common initial complaint or depression as a misdiagnosis of the disease. In addition, it is possible that depression is an integral concomitant of the disorder and is a treatable secondary symptom. There is some overlap in medication usage between the two diseases, and levodopa preparations have been tried as therapy for depression.[10] It is possible that levodopa and other anti-Parkinson therapies may themselves trigger depression in some individuals, and certainly many note a sense of failure of therapy and disappointment six to eight months after initiation of therapy.

More serious psychological problems, including frank psychosis or dementia, have also been linked with parkinsonism. Whether these are an integral part of the disease itself is open to question, but most neurologists feel that dementia is part of late-stage parkinsonism for many patients. Psychosis or dementia may also be triggered by therapy, and Marsden[11] and others[12] have suggested that the changes in mentation may be accelerated by use of levodopa inappropriately or too soon for parkinsonian patients. Parkinsonism is characterized by loss of motor activity, a loss that can be as striking as any sensory deprivation. Such lack of feedback from the motor system may affect the sense of well being. Furthermore, there is a social and cultural deprivation in parkinsonian patients as they become unable to interact with the community.

Cortical atrophy in patients with parkinsonism can lead to dementia, but some patients with extrapyramidal disease may have what has been called "subcortical dementia."[13] In this there is more of an appearance of dementia than true confusion, since the biggest deficit is delay in response rather than failure of response.

What then are the treatable psychological aspects of parkinsonism? The first and most obvious aspect is depression. Parkinsonian patients can respond to tricyclics and small doses of tricyclics such as amitriptyline (Elavil)® are almost as effective for parkinsonian symptoms as the use of trihexphenidyl (Artane).® The extreme anxiety seen in some patients with parkinsonism responds to tranquilization, and though phenothiazines are logically contraindicated in parkinsonism, small doses of thioridazine or related drugs can help calm some patients. It is possible that the commonly used diphenhydramine hydrochloride (Benadryl),® in addition to its atropine effect, also benefits patients as a sedative. The tendency toward isolation and deprivation can be counteracted by psychotherapists, including family, religious leaders, friends and lay agencies.

What effects of the medication are of psychiatric significance? Though many patients are bitter about tremor, the dyskinesias secondary to levodopa therapy often are ignored or not noticed by the patient. Anticholinergics have an atropine-like effect, and can certainly affect orientation and memory. As high as 10% of patients may develop nocturnal confusion when given large doses of anticholinergics. Levodopa may have an adrenalin-like effect, and through

"More serious psychological problems including frank psychosis or dementia have also been linked with parkinsonism for many patients."

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the catecholamine system can lead to transient psychosis, agitation or hallucinations. Some of the medicines produced sedation. Levodopa may affect the locus ceruleus and lead to unusually intense dreaming or nocturnal hallucinations. Medications may have an effect on the bladder and on the autonomic systems, and by this means produce additional distress, anxiety and agitation.

Who can do psychotherapy for the patients? The medical team, including social workers, psychiatrists and other physicians are helpful as ancillary counselors. Spouse, children and neighbors are undoubtedly of particular value, with religious leaders and professional associates of great importance to individual patients. Group activities and supporting organizations can make a major contribution for some patients.

SUMMARY

Parkinsonism can occur in any population group, but since it tends to begin in the later years of life, the emotional difficulties of this period are increased by this disorder. Depression in particular appears to be linked to

"Parkinsonism can occur in any population group, but since it tends to begin in the later years of life, the emotional difficulties of this period are increased by this disorder."

It must be recognized that there are normal phenomena that complicate the life of many parkinsonian patients. The patients are aging; in fact, Barbeau suggests that parkinsonism is one aspect of aging that everyone will have if only they live long enough.[14] In the decades of the '50s, '60s and '70s, loss of loved objects is not unexpected, and concomitant diseases not related to parkinsonism are almost universal. The reaction of the family to chronic disease is triggered to some degree by the age of the patient and related to the financial insecurity of the aged and without doubt the impact of unanticipated disease can overwhelm patients and their partners.

Parkinsonism and may respond to therapy independent of the motor disability due to the extrapyramidal disorder. The drugs used in treatment



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and the disease may produce confusion, hallucinations, and vivid dreaming. Despite these psychologic aspects of the disorder, most patients with Parkinsonism are not psychiatrically ill and the emotional disturbances linked with the disease generally can be managed by the family physician. OSMA

George Paulson, M.D., is a member of the OSMA, President of the Academy of Medicine of Columbus and Franklin County and practices neurology in Columbus.

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BOYNE HIGHLANDS

Harbor Springs, MI

NAME AND GROUP CONTACT	ARRIVAL/ DEPARTURE	TYPE
EMERGENCIES IN MEDICINE Dr. Robert Wilson	1/10-1/15, '82	
TRI-STATE DENTAL Dr. Donald DeCenso	1/10-1/15, '82	
OHIO VETERINARY MEDICAL ASSOC. Dr. George Norris	1/24-1/29, '82	
FAMILY PRACTICE UP-DATE CONFERENCE Janet Johnson	1/31-2/5, '82	
MICHIGAN OPTOMETRIC ASSOCIATION Dr. Phillip Irlon	2/14-2/19, '82	
BOYNE WINTER IMAGING SEMINAR Dr. Robert Bree	2/14-2/19, '82	

BOYNE MOUNTAIN

Boyne Falls, MI

MID-WINTER MEDICAL MEETING Dr. Michael Hughes	1/24-1/29, '82	
MICHIGAN HEART ASSOCIATION Eleanor Peterson, R.N.	1/31-2/5, '82	

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AMERICAN ASSOCIATION OF DENTISTS Morris Travel	1/16-1/23	National
ACADEMY OF FAMILY PHYSICIANS D.J. Breen, MD Hillsboro Clinic	1/24-1/30	National
MONTANA PHYSICAL THERAPY ASSOC. Diane C. Allen, LPT	1/22-1/24	State
BIG SKY RADIOLOGY Dr. Virgil B. Graves Dept. of Radiology Columbus Hospital	2/1-2/6	National
MONTANA ACADEMY OF OPHTHALMOLOGY Dr. Kenneth Younger	2/11-2/14	Regional
MONTANA ACADEMY OF DERMATOLOGY Dr. Ronald Orman	1/12-2/15	Regional
CARDIOLOGY SEMINAR Dr. Sidney Goldstein Head-Division of Cardiovascular Medicine Henry Ford Hospital	2/13-2/20	National
TRI-STATE DENTAL/ MEDICAL Hugh Henning, DDS	2/20-2/27	Regional
TOPICS IN INTERNAL MEDICINE Frances Burt	2/23-2/28	National
ANESTHESIOLOGY SEMINAR Mrs. Phyllis Sherburne Director of Educational Services Columbus Hospital	2/24-2/28	National
OB/GYN SOCIETY Dr. John Browne	3/3-3/7	Regional
BIG SKY UROLOGICAL SOCIETY Dr. Robert Towers	3/4-3/7	National
WESTERN ORTHOPEDIC ASSOCIATION James F. Schwarten, MD The Billings Clinic	3/5-3/7	Regional
CONTINUING EDUCATION SEMINAR, MEDICAL COLLEGE OF GEORGIA Morris Travel	3/7-3/13	National
MONTANA SOCIETY OF DENTISTRY FOR CHILDREN Dr. Thomas Wickliffe	3/18-3/21	State
PULMONARY DISEASES COURSE Terrie vanAllen Extended Programs in Medical Education	3/20-3/27	National
"ACHA Hospital Liability and the Quality of Patient Care" Eugenia Shuller Am. College of Hospital Administrators	1/16-1/23, '82	National
AMERICAN LUNG ASSN. OF MONTANA Earl Thomas	1/28-1/31 '82	State

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Obituaries

K. KENNEY CROOKS, M.D., Columbus; Medical College of Virginia Health Sciences Division, Virginia Commonwealth University, 1971; age 36; died September 19, 1981; member OSMA and AMA.

HAROLD G. CURTIS, M.D., Cleveland; Case Western University School of Medicine, 1930; age 76; died September 5, 1981; member OSMA and AMA.

ROY EUGENE HAYES, M.D., Elyria; University of Iowa College of Medicine, 1944; age 61; died October 8, 1981; member OSMA and AMA.

GEORGE H. IRVIN, M.D., Cleveland; New York Medical College, 1935; age 72; died September 16, 1981; member OSMA and AMA.

GEORGE D. KANELLOS, M.D., Cleveland; Faculty of Medicine University of Athens, Athens, Greece, 1939; age 69; died October 8, 1981; member AMA.

NICHOLAS KASTELLORIOS, M.D., Youngstown; Faculty of Medicine University of Athens, Athens, Greece, 1941; age 65; died September 26, 1981; member OSMA and AMA.

CARL H. LAESTAR, M.D., North Canton; Medical College Virginia Health Sciences Division, Virginia Commonwealth University, 1948; age 81; died October 2, 1981; member OSMA and AMA.

MORRIS J. LITWIN, M.D., Cincinnati; University of Cincinnati College of Medicine, 1928; age 80; died September 30, 1981; member OSMA and AMA.

NORLOSO LIVINGSTON, M.D., Columbus; Temple University School of Medicine, Philadelphia, 1945; age 63; died October 24, 1981; member OSMA and AMA.

STATES D. McCOY, M.D., Columbus; Ohio State University College of Medicine, 1931; age 78; died October 10, 1981; member OSMA and AMA.

HARRY J. MEYERS, M.D., Ft. Lauderdale, Florida; Eclectic Medical College of Cincinnati, 1924; age 86; died September 23, 1981; member OSMA and AMA.

JOHN D. MORLEY, M.D., Akron; Case Western Reserve University School of Medicine, 1933; age 72; died September 30, 1981; member OSMA and AMA.

FINLEY F. NEUMAN, M.D., Cleveland; University of Maryland School of Medicine, Baltimore, 1929; age 78; died October 8, 1981; member OSMA and AMA.

CARL HENRY REUTER, M.D., Springfield; Ohio State University College of Medicine, 1923; age 83; died September, 1981; member OSMA and AMA.

RALPH B. SAMSON, M.D., Columbus; Ohio State University College of Medicine, 1939; age 67; died October 7, 1981; member OSMA and AMA.

FRED G. SCHLECHT, M.D., Sarasota, Florida; Ohio State University College of Medicine, 1943; age 66; died September 24, 1981; member OSMA and AMA.

BERT SELIGMAN, M.D., Toledo; Wayne State University School of Medicine, Detroit, 1936; age 72; died October 14, 1981; member OSMA and AMA.

NORBERT F. SLOMER, M.D., Ft. Lauderdale, Florida; University of Cincinnati College of Medicine, 1927; age 79; died October 1, 1981; member OSMA and AMA.

FRANCIS H. STOUP, M.D., Barnesville; Ohio State University College of Medicine, 1926; age 82; died September 10, 1981.

JOHN B. TOEPFER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1937; age 71; died September 29, 1981; member OSMA and AMA.

YASHA VENAR, M.D., Cleveland; Case Western Reserve University School of Medicine, 1933; age 76; died September, 1981; member OSMA and AMA.

RALPH D. YATES, M.D., Piqua; Ohio State University College of Medicine, 1926; age 81; member OSMA and AMA.

Dawn of a new creation continued from page 700

M.D., Dayton, all participate in the arts in various capacities — from painting to music.

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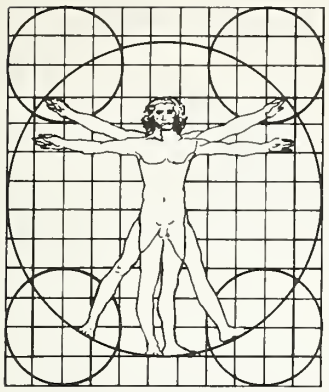


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CLINICAL & SCIENTIFIC

VITAMIN AND TRACE ELEMENT REQUIREMENTS IN PARENTERAL NUTRITION: AN UPDATE

Robert L. Ruberg, M.D.
Jay Mirtallo, M.S., R.Ph.

Recent reports have provided new guidelines for vitamin and trace element supplementation of patients receiving total parenteral nutrition. Without appropriate supplementation, patients may develop deficiency states. Zinc, copper, manganese, and chromium should be provided during prolonged total parenteral nutrition, as well as adequate amounts of both fat-soluble and water-soluble vitamins.

THE WIDESPREAD USE OF PARENTERAL nutrition technics has brought recognition of the vital role of many micronutrients for human nutrition. Most oral diets have satisfactory amounts of all of these micronutrients, so that deficiencies are encountered uncommonly, and supplementation rarely is required. On the other hand, the chemically defined nature of parenteral diets excludes many of these trace compounds. As a result, deficiency of micronutrients will occur regularly with prolonged parenteral nutrition, unless adequate amounts of these vital substances are added to the infusion mixtures.

The requirements for and provision of two important classes of micronutrients, trace elements and vitamins are discussed.

Trace Elements - Definitions

A trace element is a substance present in human tissue in minute amounts. These elements may be present in tissues in micrograms or even picograms of wet organ weight. Certain important elements are recognized easily as *macronutrients* — for example, sodium, potassium, chlorine, calcium, phosphorus, and magnesium. These elements are present in large amounts in human tissues, and must be added promptly to parenteral diets when oral nutrition is denied for any length of time.

Certain elements may be considered intermediate in amount. Iron, which is found in many important body constituents, is probably the best example of such an element. Parenteral supplementation of iron may be necessary in certain circumstances.

The *micronutrients*, or trace elements, are present in tiny amounts, yet they also are essential to normal human existence. We can recognize three important functions of these trace elements:[1] Certain trace elements play a critical role in enzyme function. They can complex with protein to form what sometimes is called a "metalloenzyme." Secondly, trace elements participate in protein and nucleic acid synthesis, and may be vital to the structural stability of these substances. Thirdly, some trace elements have a role in membrane transport, mitochondrial function, nerve conduction, and muscle contraction.

The Essential Trace Elements

Certain of the trace elements clearly determined to be essential for human existence[1,2] are iodine, cobalt, zinc, and copper. Two additional elements — chromium and manganese — are most likely essential, although the evidence for their necessity is not as strong. Several other elements that are commonly found in human tissues and are considered to be probably essential are selenium, molybdenium, vanadium, nickel, tin, and silicon. There is also evidence suggesting that fluorine and arsenic are essential trace elements.

Deficiencies of any of the essential trace elements may produce significant problems. The consequences of lack of iodine, iron, and cobalt (as vitamin B_{12}) are well described and commonly recognized. The following is a discussion of the consequences of several less common deficiency states.

Trace Element Deficiencies

The prolonged use of parenteral nutrition without trace element supplementation has led to the appearance of certain

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Submitted December 15, 1980.

clinically evident deficiencies. Probably the most frequently described trace element deficiency involves zinc.[3-5] Zinc is present in many body constituents. The total body content in an adult is two to four grams, and it is an essential component of more than 70 metalloenzymes (for example, carbonic anhydrase, alcohol dehydrogenase, and alkaline phosphatase). Zinc is crucial for growth and development as well as for normal adult physiologic function.

Zinc deficiency may produce acrodermatitis enteropathica (severe, chronic diarrhea and roughened, thickened, ulcerated skin on extremities and around body orifices), hypogeusia, alopecia, growth retardation, and gonadal atrophy. The effects of zinc upon wound healing are somewhat controversial. There is disagreement as to whether supplemental zinc can accelerate wound healing in the absence of zinc deficiency, but when deficiency is present, wound healing is certainly impaired.

About one third of an oral dose of zinc is absorbed. It is distributed first to the liver, then to muscle, red cells, bone, and skin. Most of the storage of zinc is intracellular, and excretion is mainly via the feces. For a single given dose, in 21 days 70% will have been excreted in the feces and 2% in the urine, with 28% retained.[5]

Copper deficiency also has been described as a consequence of total parenteral nutrition.[6,7] The total body content of copper is about 100 mg to 150 mg, and it is an important component of a number of metalloenzymes, including cytochrome C oxidase, tyrosinase, and monoamine oxidase. Copper deficiency produces hematologic effects, including anemia, neutropenia, and leukopenia. A human disease called Menke's Syndrome, or Menke's Kinky Hair Disease, is caused by copper deficiency. This syndrome is an X-linked fatal disease, which is not cured by copper supplementation.

Approximately 30% of an oral dose of copper is absorbed. It is distributed mainly to the liver with smaller amounts going to bone and muscle. The majority of the retained copper (90% to 95%) is bound to ceruloplasmin; excretion, as with zinc, is principally through the feces.

Chromium is another trace element for which a deficiency state related to total parenteral nutrition has been described.[8] Chromium is critical for glucose metabolism, perhaps through mediation of insulin effects on membranes. Chromium deficiency results in impaired glucose tolerance, an effect which is insulin-resistant.

Manganese is a trace element with a critical role in the activation of many enzyme systems, including alkaline phosphatase, arginase, and cholinesterase. It also is part of the metalloenzyme pyruvate carboxylase. An administered dose of manganese is distributed to brain, pancreas, liver, and kidney. In general it is found in highest concentration in tissues rich in mitochondria. Manganese deficiency produces impaired growth, skeletal abnormalities, reproductive dysfunction, ataxia, and convulsions.

Trace Element Requirements

Trace element requirements for oral nutrition are fairly well defined, and can be found listed as part of the Recommended Dietary Allowances (RDA) published by the National Academy of Sciences and National Research Council.[9] Iron, iodine, and cobalt (as B_{12}) requirements are met easily with commonly available preparations.

The remainder of the trace element requirements has been determined as part of the RDA for oral nutrition, but until recently no guidelines existed as to how these requirements should be modified for parenteral administration. In response to the need created by the widespread use of prolonged parenteral nutrition, an expert panel recently has published guidelines for trace element supplementation for parenteral use.[2] These requirements are listed in Table 1, with the oral requirements also illustrated for comparison. The reduced IV requirement occurs because of the limited absorption of an oral dose of the trace elements. As yet no supplementation of other trace elements has been recommended but reports of deficiency states of additional elements (eg, selenium, molybdenum) may change this situation some time in the future.

Table 1. **Daily Requirements for Trace Elements**

	Oral	I.V.
Zinc	15 mg	2.5 - 4.0 mg
Copper	2.0 - 3.0 mg	0.5 - 1-5 mg
Chromium	0.05 - 0.2 mg	10-15 mcg
Manganese	2.5 - 5.0 mg	0.15 - 0.8 mg

Under special circumstances, supplementation of trace elements beyond the levels recommended above may be necessary.[5] These special requirements for zinc and chromium supplementation are listed in Table 2.

Parenteral Trace Element Solutions

Oral diets rarely require trace element supplementation. On the other hand, all patients receiving parenteral diets for any prolonged period should receive trace element solutions as part of their daily program. The "expert panel" has recommended that separate solutions be used for each of the trace elements. At the Ohio State University Hospitals we have modified this recommendation by preparing only two solutions, one with all four replacement elements, and a second with zinc alone. These solutions are illustrated in Table 3. With these two solutions, we generally are able to provide satisfactory amounts in all routine and most special situations.

We utilize 3 ml per day of the mixed solution in most patients. The zinc-only solution then can be used to supplement patients in an acutely catabolic state, or those with significant gastrointestinal losses. By following the above guidelines we are able to avoid trace element deficiencies, and provide critical micronutrients for normal physiologic function.

Vitamins - Definitions

Vitamins, similar to trace elements, are substances present in human tissue in small amounts. These chemicals are organic compounds that are neither carbohydrate, protein, nor

Table 2. **Trace Elements-Special Requirements**

Acute Catabolic State

2.0 mg Zinc

Gastrointestinal Losses

12.2 mg Zinc per liter small bowel fluid

17.1 mg Zinc per kg stool or ileostomy fluid

20 mcg Chromium

Table 3. **OSU Trace Element Solution**

#1	Zinc	1 mg/ml
	Copper	0.4 mg/ml
	Chromium	4 mcg/ml
	Manganese	0.1 mg/ml
#2	Zinc	1 mg/ml

fat, but are necessary for the body to maintain normal biologic activity. Vitamins function as regulators or coenzymes in the metabolism of energy-yielding nutrients such as carbohydrates, and therefore coordinate tissue growth and maintenance, as well as assist in the storage and utilization of energy.

The human body is incapable of synthesizing vitamins in the amounts needed for homeostasis, and must receive adequate amounts from exogenous sources.

Vitamins - Classifications

Thirteen vitamins are required by the human body. These are divided into two classes: water-soluble and fat-soluble vitamins.

The water-soluble vitamins include thiamine (vitamin B_1), riboflavin (vitamin B_2), nicotinic acid (NI), pantothenic acid (PA), pyridoxal (vitamin B_6), biotin (Bi), folic acid (FA), cyanocobalamin (vitamin B_{12}), and ascorbic acid (vitamin C). These compounds serve the traditional vitamin roles as coenzymes, and most of their functions have been clearly delineated.

The fat-soluble vitamins include vitamins A, D, E, and K. This class of vitamins is required only by complex organisms, possessing an advanced division of labor among their cells and tissues. Although the functions of these vitamins are well described, their roles as coenzymes in biochemical reactions are not established yet.

Vitamins - Requirements

The vitamin requirements for oral nutrition of healthy individuals have been well established and are listed as part of the Recommended Dietary Allowances (RDA) published by the National Academy of Sciences and National Research Council (Table 4).[9] For an individual receiving a well-balanced oral diet consisting of the four basic food groups (fruit and vegetable, grain, meat, and milk groups), vitamin supplementation rarely is required.

When nutrition via the gastrointestinal tract is not possible for prolonged periods of time, total parenteral nutrition (TPN) may be required. Parenteral multivitamin preparations (Table 5) have been made available for incorporation into TPN formulas in order to assure the nutritional completeness of the feeding program.

The efficacy of many of the currently available multivitamin preparations has not been proven and is under investigation. One parenteral vitamin formulation, MVI^R (Table 5) was investigated by Nichoalds, et al.[11] This study found that 1.4 ml of MVI^R (10 ml vial) supplemented with 200 mcg of folic acid, 70 mg of ascorbic acid, and 5 mcg of vitamin B_{12} per liter of TPN infusate, was needed to produce normal serum vitamin levels in 45 patients receiving total parenteral nutrition. Normal serum vitamin levels were achieved within two weeks of initiating TPN therapy (averaging three liters of infusate per patient per day) and maintained at that level with continued treatment.

Recommendations for intravenous (IV) and intramuscular (IM) vitamin formulations were prepared by the Nutrition Advisory Group (NAG) of the American Medical Association (AMA) in 1975.[10] In general, the IV formulation is considered necessary for long-term TPN therapy for nutritional rehabilitation and maintenance of patients. Also, multivitamin preparations for IM administration may be useful for immediate

Table 4. **Recommended Dietary Allowances (RDA) for Vitamins Per Day**

Vitamins	RDA Adults	RDA Age 11 yr and Under	RDA Infants* 0-0.5 yr	RDA Infants* 0.5-1.0 yr
A (retinol), IU	4000-5000	2000-3000	233	222
D, IU	400	400	66	44
E (Alpha tocopherol), IU	12-15	7-10	0.66	0.55
B_1 (thiamin), mg	1-1.5	0.7-1.2	0.055	0.55
B_2 (riboflavin), mg	1.1-1.8	0.8-1.2	0.07	0.07
nicotinic acid, mg	12-20	9-16	0.9	0.8
pantothenic acid, mg	5-10			
B_6 (pyridoxal), mg	1.6-2	0.6-1.2	0.05	0.04
C (abscorbic acid), mg	45	40	6	4
folic acid, mcg	400	100-300	8	6
B_{12} (cyanocobalamin), mcg	3	1-2	0.04	0.03
biotin mg	150-300			

*Recommendations listed as units per Kg body weight per day.
IU = International Units

Table 5. **Commercially Available Parenteral Vitamin Formulations**

Formulation	Manufacturer	Pack Size	A IU	D IU	E IU	B_1 mg	B_2 mg	N1 mg	PA mg	B_6 mg	C mg	FA mcg	B_{12} mcg	Bi mcg
Berocca-C®	Roche Labs	2 ml				10	10	80	20	20	100			200
Betalin Complex R.C.®	Eli Lilly & Co.	10 ml				25	6	100	5	10	500			
Folbesyn®	Lederle Labs	2 ml				10	10	75	10	15	300	1000	15	
Solu B with C	Upjohn Co.	5 ml				10	10	250	50	5	500			
Vi-Cert	Travenol Labs	10 ml				25	10	100	20	20	500			
Bejectal-C®	Abbott Labs	10 ml				200	30	750	50	50	1000		20	
Lyo B-C Forte	M.S. & D.	7 ml				98	9.8	497	49	9.8	497		24.5	
Solu B Forte	Upjohn Co.	10 ml				250	50	1250	500	50	1000			
MVI® Concentrate	USV Pharm. Corp.	5 ml	10,000	1,000	10	50	10	100	25	15	500			
MVI-12®	USV Pharm. Corp.		3,300	200	5	3.0	3.6	40	15	4	100	400	5	60

treatment of deficiency resulting from poor absorption or insufficient oral intake.

Most of the available parenteral vitamin preparations prescribed for the purposes mentioned above (Table 5) have been found to be deficient. For some time, the most complete formulation available for parenteral use was MVI^R (USV), which contains both fat- and water-soluble vitamins for intravenous use but lacks biotin, folic acid, vitamin B_{12}, and vitamin K. This has prompted some centers to include Folbesyn® and/or Berocca-C® into the TPN formula. Additionally, B_{12} and K were administered intramuscularly.

The current AMA/NAG recommendations for parenteral vitamin formulations are listed in Table 6. These new guidelines were designed to eliminate the inadvertent omission of certain necessary vitamins, prevent the overdosage of vitamins such as the fat-soluble group which may be stored by the body and not rapidly excreted, minimize prompt excretion that results from too rapid administration of water-soluble vitamins, and dispense with the need for supplementary IM injections. The predominant difference between the AMA/NAG recommendations and the majority of the commercially available formulas is the reduction of B complex and fat-soluble vitamins, and the addition of folic acid, vitamin B_{12}, and biotin. A recently introduced product, MVI-12^R (Table 5), has been formulated to correspond to the AMA/NAG recommendations (Table 6). We now are utilizing this product daily, and providing vitamin K supplementation by weekly IM injection.

These recommendations are designed to meet the needs of healthy individuals and do not take into account the possible special needs of patients with infection, metabolic disorders, chronic diseases, or trauma. In addition, certain drugs may interfere with absorption or metabolism of specific vitamins. Therefore, preparations of individual vitamins for parenteral use still remain available for treatment of specific deficiencies.

Table 6. **American Medical Association (AMA), National Advisory Group (NAG) Recommendations for Parenteral Vitamin Formulations**

Vitamins	Adults IV	Adults IM
A (retinol), IU	3,300	
D, IU	200	
E (Alpha tocopherol), IU	10	
B_1 (thiamin), mg	3.0	3.0
B_2 (riboflavin), mg	3.6	3.6
nicotinic acid, mg	40	40
pantothenic acid, mg	15	15
B_6 (pyridoxal), mg	4	4
C (ascorbic acid), mg	100	100
Folic acid, mcg	400	400
B_{12} (cyanocobalamin), mcg	5	5
Biotin mg	60	60

Conclusions

The recent recommendations by expert panels for trace element and vitamin supplementation during parenteral nutrition therapy provide extremely useful guidelines for clinicians. With appropriate modifications for individuals with extraordinary needs, these guidelines permit prolonged safe total parenteral nutrition.

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Medical Crossword

By R. M. Benson, M.D.

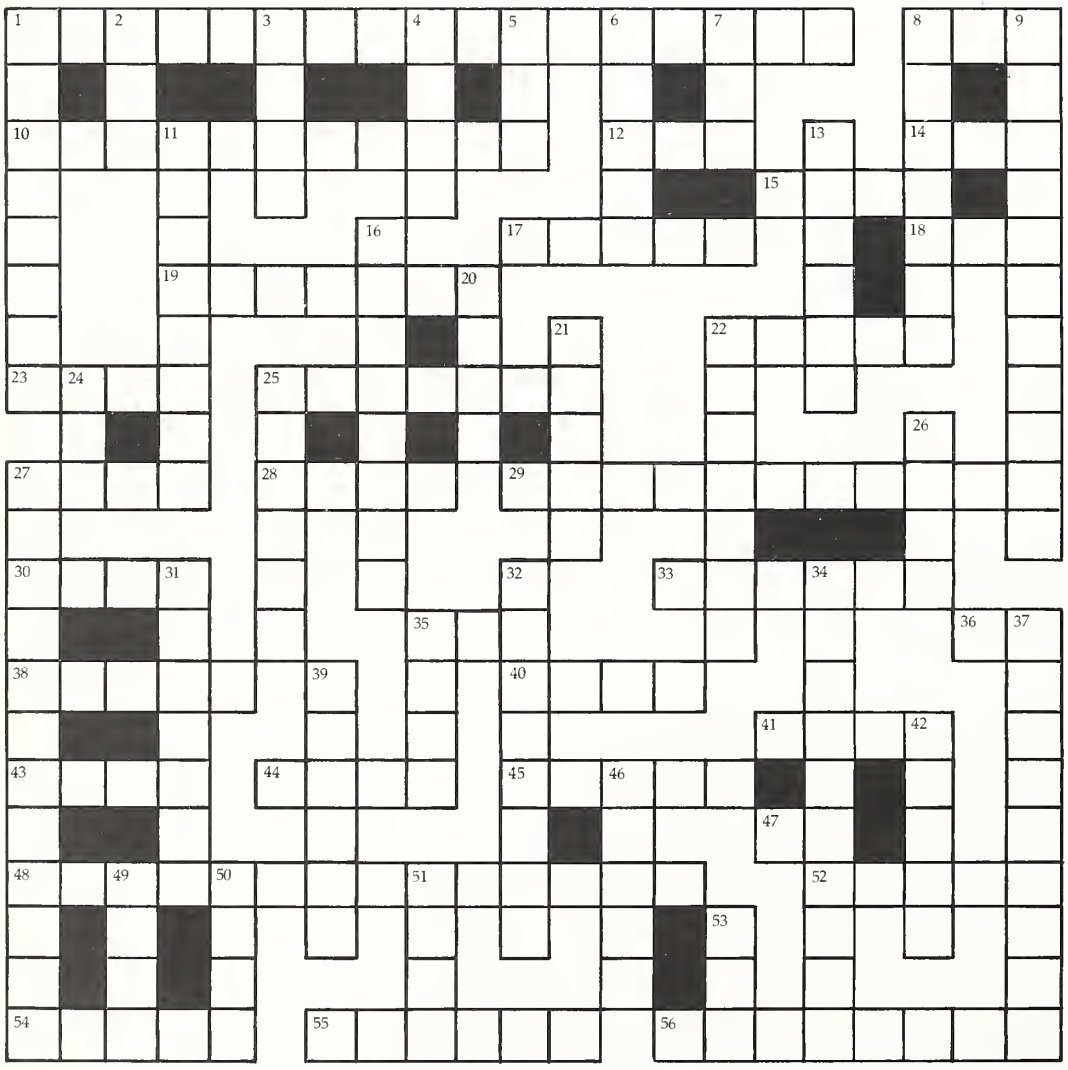
SHORT STATURE

ACROSS:

1. Rathkes pouch tumor, 8. Pituitary hormone elevated in hypothyroidism, 10. Liver generated growth hormone mediator, 12. Optic organ, 14. Tear, 15. Element essential for hemoglobin, 17. Hypoplasia syndrome with hypopituitarism and absent septum pellucidum, 18. Consume, 19. Bone age in hypothyroidism, 22. Species class, 23. Observes, 25. Xray study important to short stature evaluation, 27. Bacon sources, 28. Raining ____ and dogs, 29. Syndrome of obesity, hypotonia, hypogonadism, and hypomentia, 30. Twelve months, 33. Easy, 35. Standard deviations defining the normal range, 36. TSH level in primary hypothyroidism, 38. What chicks do from eggs, 40. The yellow brick ____, 41. Birth size in fetal alcohol syndrome or Russel Silver dwarfism (abbr.), 43. Identical, 44. ____ with the wind, 45. Bombay's country, 47. Common Karyotype in eight down, 48. Short stature of innate slow biological time clock with no hormonal dysfunction, 52. Blood pumping organ, 54. Dwarfism with high GH and low somatomedin, 55. RBC problem causing slow growth, 56. Rate of growth.

DOWN:

1. Hypercortisol syndrome, 2. Ready, ____, fire, 3. Aroma, 4. Amos and ____, 5. Strong desire, 6. Alexander the ____, 7. Lyric poem, 8. Syndrome of short stature and gonadal dysgenesis, 9. Patient with slow growth, dry skin, and cold intolerance, 11. Renal tubular abnormality causing slow growth, 13. Inflammatory bowel disease causing slow growth, 16. Type of heart disease causing poor growth, 20. Defunct, 21. Striped animal, 22. Pertaining to heredity, 24. Prefix with dermis and staxis, 25. Smear study essential in evaluating short females, 26. Sky and sea color, 27. Dwarfism with bizarre eating habits and food hoarding, 31. Short stature disease of wide metaphyses and decreased osteoid mineralization, 32. Adrenal hormone whose excess can slow growth, 34. Parathyroid disorder with short stature, mental retardation, short metacarpals, and hypocalcemia, 35. "A ____ of Two Cities", 37. Gland source of growth hormone, 39. Hormone generating somatomedin, 42. Take it easy!, 46. Abnormally small person, 49. Close to, 50. Ripped, 51. Skin test for TB, 53. Woodman's tool.



(solution is on page 732)

Dr. Benson is the Director of Pediatric Endocrinology at Children's Hospital Medical Center, Akron.

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